

# CENTRAL TEXAS ORTHOPEDICS

PERSONAL PATIENT INFORMATION: 2011

\_\_\_\_\_  
Patient: Last Name                      First Name                      Middle Initial                      DOB  
Sex: M    F    (circle one)              Marital Status: Single    Married    Divorced    Widowed (circle one)

\_\_\_\_\_  
Address    City                      State                      Zip Code

\_\_\_\_\_  
Parents Name (if minor)                      Address of Parent                      State                      Zip Code

\_\_\_\_\_  
Home /Cell Phone Number                      Work Phone Number and Extension

\_\_\_\_\_  
Drivers License #                      Social Security #                      E-Mail Address

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

**Insurance Information:**

Primary Insurance Carrier: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security #: \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact Information:**

\_\_\_\_\_  
Emergency Contact    Relationship    Phone #

**Private Insurance Authorization for Assignment of Benefits/Authorizations/Information Release:**

I, the undersigned, authorize payment of medical benefits to Central Texas Orthopedics for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_\_  
Patients Signature    Printed Name    Date

**CENTRAL TEXAS ORTHOPEDICS**

**Scott Welsh, M.D. P.A.**

**AGREE AND CONSENT**

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy.

**PRIMARY INSURANCE:**

- We will bill your **PRIMARY** insurance as a courtesy.
- A current insurance card must be provided at the beginning of each visit. Payment will be expected at the time of service if eligibility cannot be verified.
- Insurances will be verified for eligibility and benefits prior to your appointment.

**SECONDARY INSURANCE:**

- We will submit claims to a secondary insurance if we are contracted with that insurance.

**PAYMENTS:**

- Co-pays, co-insurance and deductible payments are due at the time of service.
- Patients without insurance are expected to pay in full at the time of service.
- We accept Visa, MasterCard, Discover, American Express, Debit, Checks and Cash. In the event you cannot make your payment in full on the day of service a credit card number will be put on file and charged monthly till all balances are paid in full.

**Fees:**

- There is a \$15.00 charge for filling out Disability Forms and other like paperwork.
- There is a \$50.00 No Show Fee or Cancellation of less than 24 hours.
- There is a \$30.00 Return Check fee.
- We reserve the right to forward any past due balance(s) to a third party for collection purposes, we also reserve the right to collect past due balance by whatever means necessary.

---

I do hereby consent to and authorize the performance of all examinations, x-rays, treatments, Durable Medical Equipment, and medical services by Scott A. Welsh, M.D. P.A. and their staff, which they deem advisable. I also acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay Scott A. Welsh M.D. P.A. (Central Texas Orthopedics) directly. A copy of this authorization can be considered an original for insurance purposes.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Patient Representative/Relationship to Patient:

---

Required if patient is a minor or adult who is unable to sign this form

### Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Central Texas Orthopedics reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or request a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed below will require a specific authorization prior to disclosure of any medical information.

\_\_\_\_\_  
Patient/Legal Representative Printed Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Dr. Welsh to share my protected health information with:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

I wish to be contacted in the following manner:

\_\_\_\_\_ Home/Cell Phone

\_\_\_\_\_ E-Mail

\_\_\_\_\_ Work Phone

Ok to leave message with detailed information:

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ Yes

\_\_\_\_\_ No

#### RELEASE OF INFORMATION:

Central Texas Orthopedics is hereby authorized to furnish medical information as may be necessary for the payment of all charges by my insurance carrier, Medicare, Medicaid, or any other payer or agency, from the medical records compiled during the duration of my care. This waiver also authorizes release of copies of my medical records to healthcare practioners and organizations who are involved in my continued care. Central Texas Orthopedics will only release my healthcare information as specified by state law. I understand that I have the right to obtain copies of my healthcare records/information for a fee.

\_\_\_\_\_  
Patient/Authorized Representative's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Office Staff

\_\_\_\_\_  
Date

Notice of Privacy Practices  
Central Texas Orthopedics  
7900 FM 1826, Suite 120  
Austin, Texas 78737

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations: We will use and disclose your protected health information to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information

Appointment Reminders: We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives: We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care: We will use and disclose your protected health information to a family member, a relative, a close friend or any other person you identify that is involved in your medical care or payment for care.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

To Avert a Serious Threat to Public Health or Safety: We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury or disability. If directed by the health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation: We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates: We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of the correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with healthcare, to protect the health and safety of others, or for the safety and security of the correctional institution.

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you.

You have the right to:

## Notice of Privacy Practices

**A Paper Copy of This Notice:** You have the right to receive a paper copy of this notice on request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

**Inspect and Copy:** You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psych-therapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager at Central Texas Orthopedics, 7900 FM 1826, Suite 120 Austin, Texas 78737. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

**Request Amendment:** You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part to the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

**Request Restrictions:** You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

**An Accounting Disclosure:** You have the right to request a list of the disclosures of your health information we have made outside of your practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

**Request Confidential Communications:** You have the right to request how we communicate with you to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

**File a Complaint:** If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Central Texas Orthopedics, 7900 FM 1826, Suite 120, Austin, Texas 78737. You should know that there would be no retaliation for your filing a complaint.

### Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at 512-322-9163

Effective date 11/10/2008

**CENTRAL TEXAS ORTHOPEDICS**

**Scott A. Welsh, M.D.**

**Certified American Board of Orthopedic Surgery**

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date of Birth

**RELEASE OF INFORMATION:**

Central Texas Orthopedics is hereby authorized to furnish medical information as may be necessary for the payment of all charges by my insurance carrier, Medicare, Medicaid, or any other payer or agency, from the medical records compiled during the duration of my care. This waiver also authorizes release of copies of my medical records to healthcare practioners and organizations who are involved in my continued care. Central Texas Orthopedics will only release my healthcare information as specified by state law. I understand that I have the right to obtain copies of my healthcare records/information for a fee.

\_\_\_\_\_  
Patient/Authorized Representative's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Office Staff

\_\_\_\_\_  
Date