Family Orthopedics and Rehabilitation, LLP

We're Here F.O.R You!

609 Matlock Centre Circle, Arlington, TX 76015

familyorthopedics.net

(817) 276-8888 or (817) 676-9046 Fax (817) 676-9050

Christine Huynh, M.D.
Board Certified Physical Medicine & Rehab
EMG/ Nerve Conduction Study, Pain Management

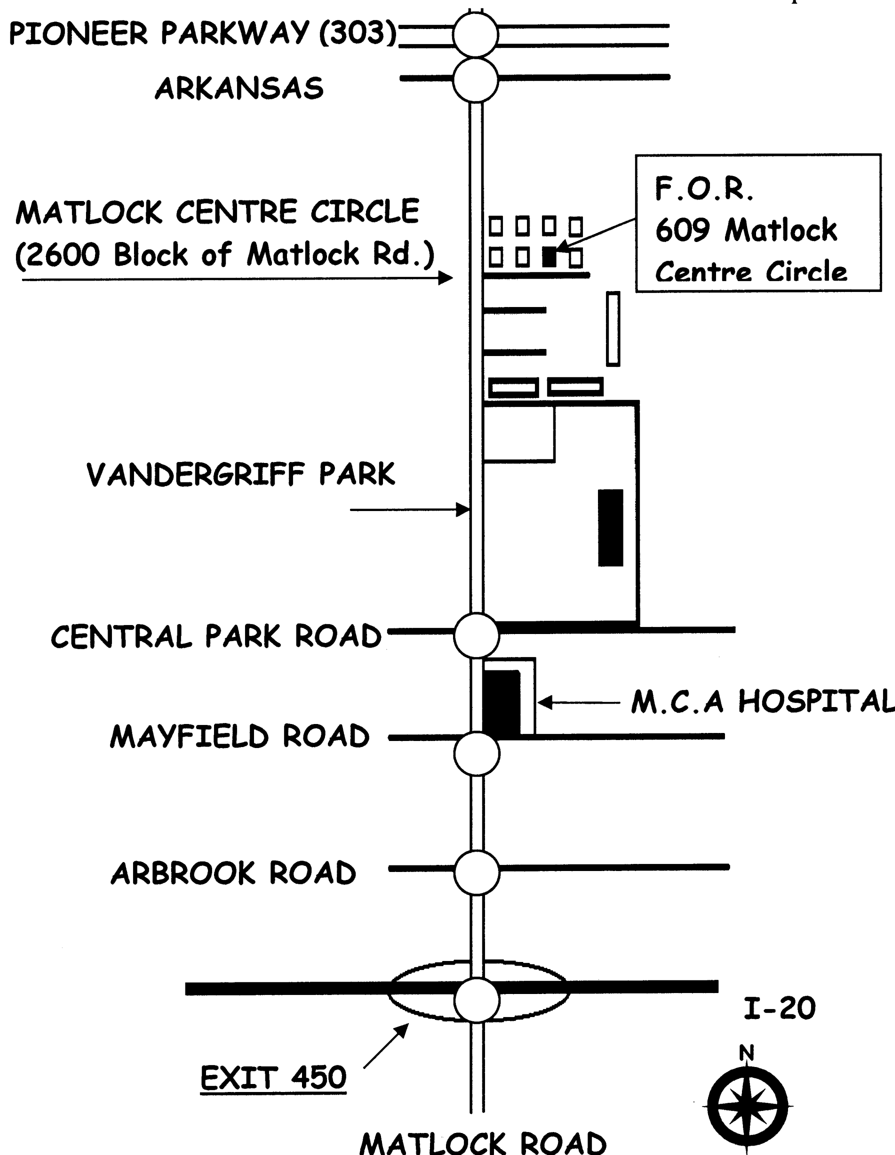
Christopher Wong, M.D.
Board Certified Orthopedic Surgeon ABOS
General Orthopedics & Sports Medicine

Paul Chong, M.D.
Board Certified Orthopedic Surgeon
General Orthopedics & Sports Medicine/Shoulder

Jacob Chun, M.D.
Board Certified Orthopedic Surgeon ABOS
General Orthopedics and Sports Medicine specializing in Total Joint Replacement & Ligament Reconstruction

Henry Chou, D.O.
Board Certified Physical Medicine & Rehabilitation
Interventional Pain Management

We provide treatment for fracture care, shoulder, elbow, wrist & knee pain/injuries, carpal tunnel, neuropathy, neck & back pain. Botox treatment for migraine headaches.



**BRING YOUR INSURANCE CARD, PICTURE ID, ALONG WITH COMPLETED NEW PATIENT PAPERWORK

New Patient Forms are available at *FAMILYORTHOPEDICS.NET*

BRING WITH YOU
ANY DIAGNOSTIC EXAMS, SUCH AS: FILMS & REPORTS FOR X-RAYS, MRI, CT SCANS, (THAT PERTAINS TO THE INJURY)

○ = TRAFFIC LIGHT

Family Orthopedics and Rehabilitation

609 Matlock Centre Circle, Arlington, TX 76015

Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are US or foreign military forces / veteran and if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are in inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information and communications:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office manager.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and give the reason for amendment, and submitted to the office manager.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time from our office.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice manager or with the Secretary of the Department of Health and Human Services.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
   Contact our privacy officer for any questions.

Family Orthopedics and Rehabilitation *(F.O.R)* **Demographic/ Consent Form**

Chris Wong, MD ***Paul Chong, MD*** ***Christine Huynh, MD*** ***Jacob Chun, MD*** ***Henry Chou, DO***

Date completed ________________ PCP / Referring physician ___________________________

Patient Name: Last: ____________________ First: ____________________ MI: _________

Social Security #: _____________________ Birth Date: ________________ M_______ F______

Address: _________________________ APT#______ City____________ State _____ Zip Code ________

Appointment Reminder Preference: Cell(Text) ____ Cell Phone ____Home # ___ E-mail ____

Phone Number: Home # _______________Cell # _______________ Work # _______________

E-mail ____________ @________ Work Status: ☐ **Active** ☐ **Retired** ☐ **Disabled**

Employer: _____________ Contact Phone: ____________ ☐ **WC/Injury DOI:** _________

Insured Info: Name__________________________ SS#________________ DOB: _________

Primary Insurance: __________________ **Secondary Insurance:** ____________________

Emergency contact: 1.__________________________ Phone: ____________________________

2.__________________________ Phone: ____________________________

I authorize my physician, F.O.R. and billing office staff to contact me and the above emergency contacts/relatives with ***no restrictions***, including discussion of medical healthcare and disclosure of personal medical records. **Initial** _______ **Date** ____________

MEDICAL CONSENT

Permission is hereby granted to the attending physician and supervised assistant to administer such medical and surgical examinations, treatments, and procedures as are deemed necessary for myself and/or the patient named or minor (<18 yr.).

Initial _________ **Date** _____________

RELEASE OF INFORMATION

F.O.R will not release any personal health information to anyone other than the patient, authorized contacts listed above, or for minors, the patient's legal guardian. Release of medical information necessary for the provision of medical care and billing purposes are automatically authorized under designated HIPAA regulations. **Initial** _______ **Date** __________

I authorize **Family Orthopedics and Rehabilitation** to furnish information to insurance carriers, Health Care Financing Administration/ Medicare/ Medicaid, Workman's comp, case manager, physicians, attorney and other related entities concerning the illness or medical treatment of my dependent or myself via telephone, fax, or in writing, in order to determine benefits, request payments and provide medical care. **Initial** __________ **Date** _________________

CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received **Family Orthopedics and Rehabilitation** Notice of Privacy Practice.

_________________________________ _______________

Signature of Patient for Medical Consent, Release of Information, HIPPA **Date**

FINANCIAL RESPONSIBILITY

I hereby assign authorized Medicare, Medicaid and Medigap, Worker's Comp benefits and all insurance payments to **Family Orthopedics and Rehabilitation** for any services (medical, surgical, therapy, DME) furnished to my dependent or my-self. This assignment will remain in effect until revoked by me in writing. I understand and agree it is my responsibility (not the responsibility of the physician/ office staff) to know regarding the medical services I receive: 1. If my insurance will pay for any medical services. 2. My deductible, co-payment/insurance, out of network amounts, usual and customary limit, or benefit of limitation. 2. If the physician I am seeing is a contracted in-network provider recognized by my insurance plan. 3. To obtain a referral from my PCP to specialist (our office) and maintain referral visits needed. **If the physician is not recognized by my insurance plan or a referral from my PCP to our office is not done, it may result in claims being denied, and I will be responsible for the out of pocket expense and any denied claim payment.** I accept responsibility for payment of all medical fees regardless of any insurance/LOP I may have to assist me in this responsibility. If for any reason my account should become delinquent, I agree to pay for all court costs, collection, finance charges & legal fees. _________________________________ _______________

Signature of Patient or Responsible Party **Date** **Rev 5.18**

History and Physical

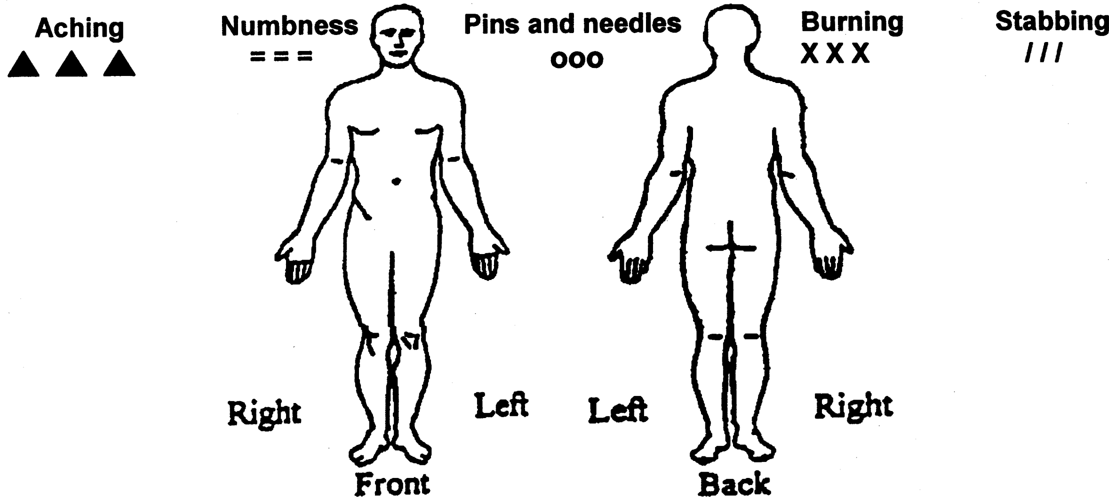
Name ____________________ Age __________ M / F Date ____________

Current Status

1. Reason for Clinic Visit ______________________ Date started ____________
2. Was there an accident or event causing your problem? Describe ________________

____

3. Do you have any pain? Where? (Draw the areas of your pain) ____________________



4. How do you describe the pain? (circle): dull, sharp, throbbing, ____________________
5. Is the pain constant or intermittent? (circle)
6. Does the pain travel anywhere? Yes / NO Where? ____________________
7. On average, what is your pain level? (0= no pain, 10= worst pain ever)
   0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10
8. What makes the pain better? ____________________

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Rest ☐ Nothing
☐ Pain pills ☐ Heat ☐ Cold ☐ Physical therapy ☐ Cortisone injection
☐ Muscle relaxant pills ☐ Anti-inflammatory ☐ Wearing brace ☐ Moving around

9. What makes the pain worse? ____________________

☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Exercise ☐ Moving around
☐ Bending forward ☐ Bending backward ☐ Sneezing ☐ Coughing ☐ Nothing

10. Do you have any numbness or tingling? Where? ____________________
11. Do you have any muscle weakness or loss of strength? Where? ________________
12. Is there any changes in your symptoms in the last 2 wks? YES / NO
    Describe ____________________
14. Do you have accident with your bowel or bladder pattern? YES/ NO ____________
15. Do you have: fever, weight loss, difficulty sleeping, loss of appetite, headache
    Probems with your: eye, ear, nose, throat, heart, lung, stomach, bladder/ kidney, joints, skin, Nerves, mood disorder, bleeding disorder, HIV, allergies (circle all that apply and explain:)

____

Previous Treatments

1. Have you had physical therapy? YES / NO When? ____________________
2. Have you tried (please circle): neck/ back traction epidural steroid injection TENSunit botox Pool therapy neurontin zanaflex elavil trazadone topamax naprosyn mobic bextra celebrex vioxx flexeril skelaxin robaxin soma acupuncture chiropractor
3. List all medications and treatments you have received for this problem. ____________

____

4. List all physicians who have treated you for this problem. ____________________

____

Continue on other side

Previous Tests

Indicate any tests you have had, date, and results:

1. X-ray/ Body part ______________________ Month/ Yr __________
   Results ______________________
2. MRI/ Body part ______________________ Month/ Yr __________
   Results ______________________
3. CAT SCAN/ Body part ______________________ Month/ Yr __________
   Results ______________________
4. EMG/ Nerve study ______________________ Month/ Yr __________
   Results ______________________

Medical History

1. Do you have: ☐ diabetes ☐ high blood pressure ☐ thyroid disease ☐ stomach ulcer/ reflux
   ☐ cancer________ ☐ arthritis__________ ☐ hepatitis ☐ HIV ☐ heart disease ☐ fibromyalgia
   other ______________________
2. List all surgeries you have had. ______________________
   ____
3. List all current medications and dosages.______________________
   ____
4. Are you allergic to any medications? ______________________
5. Are there any medical problems that run in your family? ☐ diabetes ☐ high blood pressure ☐ thyroid
   ☐ cancer ☐ bleeding disorder ☐ heart disease ☐ fibromyalgia ☐ other ______________

Social History

1. Job Position ______________________ Years worked __________
2. Are you: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Live alone Live with: __________
3. Do you smoke? Y / N : amount______pk per day Do you drink alcohol? Y / N : amount __________

STOP

Inspection______________ skin__________ circulatory__________ gait______________

ROM: neck______ back______ shoulder______ elbow______ hip______ knee______ ankle______

Palpation: paraspinal______ trap______ SI______ piriformis______ troch______ LL______ calf________

Provocative: spurling______ impinge/ss______ tinels/phalens adsons______ Finkelstein______

wadell________ SLR________ patricks______ piriformis______ quad______ obers______ trendelenburg________

Motor	Abd	EE	EF	WE	WF	FF	HF	KE	KF	DF	PF	EHL
R												
L												

Sensory________________ CN________________ FTN________ RAM________ HTS______

Reflex____________ hoffman______ clonus________ babinski______ rhomberg______