TRINITY
SPINE & ORTHO

4444 Heritage Trace, Suite 408. Keller, Texas 76244
817-283-5252, Fax: 817-283-5253
www.trinityspineortho.com

Larry M. Kjeldgaard, D.O.

Dear Patient

Thank you for choosing Trinity Spine & Ortho as your health care provider. We look forward to meeting with you to address your medical needs. In order to provide you with the best medical experience possible please help us by doing the following.

Enclosed you will find the patient information sheets for you to complete and bring with you to your first appointment. **Do not mail these forms back to us.**

Please bring the following:

All paperwork included in this packet**, completed**
Insurance card
Government issued Picture ID
MRI disc and written report
X-ray film
List of medication
Any previous medical records for the medical issue we are treating you for

If you do not bring the items listed above, we may have to reschedule your appointment. Please help us make your visit a pleasant one by bringing all the required items.

Our office policy states that co-payments and/or deductibles are due at the time of your visit. We accept Visa, MasterCard, American Express and Discover.

We reserve the right to bill for a missed or “no show” appointment without appropriate notice of cancellation.

We look forward to seeing you on your appointment day. If you have any question please call us at 817 283 5252.

Sincerely,

Trinity Spine & Ortho

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Instructions: All sections must be completed. If not applicable, please indicate as "N/A".

PATIENT INFORMATION

Last Name: ________________ First Name: ________________ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: ________________________ City: ____________ State: ____ Zip: __________

Date of Birth: _____/_____/_____ Age: ___ Social Security #: _____-_____-______ Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Home Phone: ( ) ______________ Cell Phone: ( ) ______________ E-mail Address: ________________

Race: ______________ Ethnicity: ❑ Latino ❑ Hispanic Preferred Language: ❑ English ❑ Spanish ❑ Other

Employer/School Name: ________________ Employed: ❑ Full Time ❑ Part Time Student: ❑ Full Time ❑ Part Time

Employer/School Address: ____________ City: __________ State: ___ Zip: _____ Phone: ( ) __________

Driver's License #: ____________ State Issued: ____ Primary Care Physician's Name: ________________

Pharmacy Name: ________________________ Pharmacy Phone: ( ) ____________

EMERGENCY CONTACT

Name: ________________ Relationship: __________ Phone: ( ) ____________ ❑ Home ❑ Work ❑ Cell

REFERRED BY

Doctor: ________________ Clinic: ________________ Patient: ________________

Family Member: ____________ HMO/PPO: Directory __________ Employer: ________________

Print Advertising: ____________ Internet: ________________ School: ________________

____Yes ____No Is this injury the result of a Motor Vehicle Accident?

____Yes ____No Were You Injured on the job?

If yes, have you filed a Worker's Comp Claim? ____Yes ___ No

____ Yes ____No Do you have Medicaid?

____ Yes ____No Have you had surgery in the last 90 days?

If yes, who was the Doctor? ________________________

If yes, what was the procedure? ________________________

____ Yes ____No Are you prepared to pay your portion today?

Signed________________________________ Date ____________

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Patient Name: ____ Date: __________________

PRIMARY INSURANCE	SECONDARY INSURANCE
(Please complete blanks with subscribers/primary insurance holders information)	(Please complete blanks with subscribers/primary insurance holders information)
Subscribers Name: _____________________________________	Subscribers Name: _____________________________________
❑ Male ❑ Female Date of Birth: ______/______/_________	❑ Male ❑ Female Date of Birth: ______/______/_________
Social Security #: _______________________________________	Social Security #: _______________________________________
Patient's Relationship to Subscriber: ________________________	Patient's Relationship to Subscriber: ________________________
Employer: ____	Employer: ____
Employers Address: ____________________________________	Employers Address: ____________________________________
City: ______________________ State: _____ Zip: ___________	City: ______________________ State: _____ Zip: ___________
Insurance Co. Name: ____________________________________	Insurance Co. Name: ____________________________________

GUARANTOR

❑ Patient Is Guarantor

Last Name: ______________________________ First Name: ______________________________ M.I.: ____ ❑ MALE ❑ FEMALE

Home Address: ____ City: ______________________ State: ____ Zip: ___________

Date of Birth: _____/_____/_____ Social Security #: _____-_____-______ Driver's Licence #: ________________ State Issued _______

Home Phone: ( ) ___________________ Work Phone: ( ) ___________________ Cell Phone: ( ) ___________________

Relationship to Patient: __________________ Have you ever been treated by one of the physicians at Trinity Spine & Ortho: ❑ Yes ❑ No

If Yes, which physician: _______________________________________ Approximate Date: __________________________________

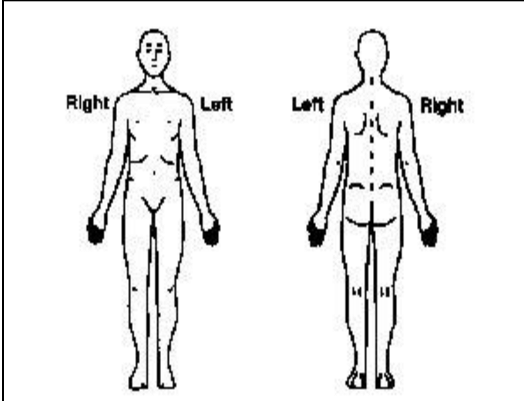
Patient Name: ____________________________ DOB: _______________ Date: _______________

ON A SCALE OF 0-10, WHERE ZERO IS NO PAIN AND 10 IS THE WORST IMAGINABLE PAIN:

Circle the number that represents your current pain level: 0 1 2 3 4 5 6 7 8 9 10

Circle the number that represents the least pain in the past 20 days: 0 1 2 3 4 5 6 7 8 9 10

Circle the number that represents the most pain in the past 20 days: 0 1 2 3 4 5 6 7 8 9 10



The body diagram to the left is used to indicate where and what type of pain you are experiencing. Mark as follows:

000= pain

IIIII= numbness

Have you had any of the following for this injury:

__ CT __MRI __EMG/NCV __Bone Scan

__X-Rays __Discogram __Physical Therapy

__ Chiropractic

IN EACH SECTION, CHECK ALL THAT APPLY TO YOUR CURRENT PROBLEM:

______ NECK PAIN ______ BACK PAIN

___ LEFT SIDE ___ RIGHT SIDE ___ CONSTANT PAIN ___ PAIN COMES AND GOES

___ LEFT LEG PAIN/NUMBNESS ___ RIGHT LEG PAIN/NUMBNESS ___ MORNING PAIN ___ EVENING PAIN

___LEFT ARM PAIN/NUMBNESS ___ RIGHT ARM PAIN/NUMBNESS ___ SHOOTING PAIN ___ BURNING PAIN

___ BOTH LEGS PAIN/NUMBNESS ___ PAIN WAKES ME UP AT NIGHT ___ MEDICATION HELPS ___ NOTHING HELPS REDUCE PAIN

___ NO BOWEL/BLADDER CONTROL ___WEAKNESS IN RT/LT LEG ___ WEAKNESS IN RT/LT ARM ___WEAKNESS IN EITHER HAND

PAIN INCREASES WITH: ___ SITTING ___STANDING ___BENDING ___SQUATTING ___WALKING ___COUGHING ___LYING DOWN

___ LIFTING ___TURNING ___JUMPING ___REACHING ___DRIVING

PAIN DECREASES WITH: ___ SITTING ___STANDING ___BENDING ___SQUATTING ___WALKING ___COUGHING ___LYING DOWN

___ LIFTING ___TURNING ___JUMPING ___REACHING ___DRIVING

Describe your pain in your own words: ____

____

Does your type of work or job tasks affect your back pain ? ___ Yes ___ No; if yes, please explain: ______________________________

____

Are you currently off work or on any type of work restrictions? ___ Yes ___ No; if yes, please list what kind and how long you have been on them:

____

Please List any medications that you are currently taking (including the amount, frequency and how long):

____

____

PAST MEDICAL HISTORY

Medical History: Please list all illnesses (Example high blood pressure, diabetes, cancer, heart, lung, liver, or kidney problems): ________________

____

____

Prior Surgeries (with dates): ____

____

Hospitalization (dates): ____

____

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FINANCIAL POLICIES

First and foremost, we would like to express our appreciation to you for selecting Trinity Spine & Ortho. We will do everything we can to answer all your questions and make this a positive experience for you.

This form represents our office policies and guidelines concerning financial matters. We ask that you read and sign this form indicating that you understand and agree to these guidelines. If you have any questions, please consult with the appropriate member of our office staff

We require a copy of your current insurance card prior to, or at the time of your visit. If you are unable to present your card, your appointment may be considered a "fee for service" visit and full payment may need to be collected. If you are an established patient, you must verify that all the information is current and accurate. If any changes have occurred, you must notify our front office staff before you are seen by a doctor.

As a rule, we try to verify all insurance and benefits prior to your appointment, but in some cases this is not possible. It is ultimately **your responsibility** to make sure that we are a participating provider on your health insurance plan and that you have active health insurance. In the event that your insurance claim is denied, you will be responsible for all billed amounts.

We will file your claims on your behalf; however, you will be responsible for any co-pays, deductibles, or coinsurance amounts according to your insurance benefits at the time of service is rendered.

HMO's and other insurance policies sometimes require a referral from your primary care physician (PCP). It is your responsibility to obtain this referral prior to your first visit. Most of the time, a phone call from you to your PCP will get this done and the referral can be faxed to our office. You are financially responsible without this referral, if required by insurance.

From time to time, insurance companies request further information from you in order to process your claim. Failure to comply with this request in a timely manner may result in denial of your claim and you become responsible for the entire amount.

All deductibles are due at the time services are rendered. For surgical patients, all deductible, coinsurance, and copays are due at least one week prior to the scheduled procedure.

Work Related Injuries: These must be disclosed at the time you are scheduled. Due to the complexity of Texas Worker's Comp., these cannot be changed from an "on the job" injury to an injury off work and vice versa. In other words, either you were injured at work or you were not. For Work related injuries, we will verify the claim with your employer, adjustor and any other appropriate entity, including other physicians, in order to best care for you and your situation. You will not be billed for any medical care or treatment related to an accepted injury and related body area that is injured. If, however, your claim is denied, you will be billed and you become responsible for the balance in full. We will work with you and assist you with understanding your situation to the best of our ability.

We accept cash, personal checks, and most major credit cards. We also offer a "pay on line" service at no extra cost to you. Log on to www.trinityspineortho.com for that information.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF TRINITY SPINE & ORTHO AS SET FORTH IN THE PRECEDING PARAGRAPHS. MY SIGNATURE INDICATES MY WILLINGNESS TO COMPLY FULLY OR ACCEPT RESPONSIBILITY FOR PAYMENTS OF ANY CLAIM DENIED DUE TO NONCOMPLIANCE. MY SIGNATURE ALSO AUTHORIZES THIS OFFICE TO FILE CLAIMS FOR ME AND ASSIGN ALL MEDICAL RIGHTS AND BENEFITS DUE FOR THESE SERVICES TO TRINITY SPINE & ORTHO. MY SIGNATURE AUTHORIZES THIS OFFICE TO RELEASE MEDICAL RECORDS AS NECESSARY TO MY INSURANCE CARRIER.

Printed Name: ___________________________________ **Date:** ________________________________

Signature: ____

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GENERAL CONSENT FOR TREATMENT:

I, knowing that I am suffering from a condition requiring diagnostic, medical, and/or surgical treatment, do hereby voluntarily consent to such procedures and care, and to such medical, surgical, or other services under the general and specific instructions of the Trinity Spine & Ortho physicians, their assistants or designees, as necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examinations by any of the physicians at Trinity Spine & Ortho, or their representative and or designees.

PRESCRIPTION POLICY:

You must talk with one of the physicians at the time of your appointment about your medication(s). The physicians will not refill your medications if you call the office for a refill. You must have your pharmacy fax a request for a refill to our offices. Allow up to 48 hours for a refill to be approved. Do not wait until you are out of medication to request a refill. Please do not try and refill your prescription at more than one pharmacy or have the same medications filled by other physicians. This will result in you being dismissed from our care.

HIPAA:

I acknowledge and understand the "Notices of Privacy Practices" that is available at the front desk or online and that I have been given access to a copy of the Privacy Practices.

DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I understand that any and all medical care that I receive at the offices of Trinity Spine & Ortho will be treated with the utmost confidentiality. To facilitate my medical care I hereby authorize Trinity Spine & Ortho to disclose PHI about my treatment and medical condition to the following individuals:

Name: ____ Relationship ________________________

Name: ____ Relationship ________________________

Name: ____ Relationship ________________________

If you have an answering machine, may we leave messages regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Trinity Spine & Ortho?

Check One Yes __________ No __________ N/A_________ Phone #:______________________

May we send electronic message (such as email or cellular text messages) regarding appointments, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Trinity Spine & Ortho.

Cellular/Mobile Phone Number __________________________________ Yes ________ No _________

Email Address __________________________________ Yes ________ No _________

____ ________________________________
Patient's printe d name Date of Birth

____ ________________________________
Signature of patient or responsible party Date

Revised 03/2014

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FORM OF PHYSICIAN DISCLOSURE

As required by Section 102.066 of the Texas Occupations Code:

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to any of the following healthcare providers for certain healthcare services:

Dr. Larry M. Kjeldgaard

Baylor Trophy Club Medical Center
Surgical & Diagnostic Center
Proguidance IOM, PLLC
Trinitas Medical Professionals
Gateway Diagnostic Imaging
Castle Therapy Partners
Nvision Biomedical Technologies Inc.

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me (i) his or her affiliation with the foregoing healthcare provider(s) for whom, I, the patient may be referred, and (ii) that he/she may receive, directly or indirectly, remuneration for the referral to such healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving healthcare services from any healthcare provider and/or facility that I choose.

____ _________________________________

Patient Signature Date