Howard W. Harris, M.D.

Mid-Cities
2425 Highway 121
Bedford, TX 76021
817-540-4477

Dear Patient,

The following forms need to be filled out before you come to your appointment. Filling out these forms completely and accurately will expedite the registration process. Please also ensure all items listed are brought with you to your appointment. Please arrive 15 minutes prior to your appointment time if you have not completed your forms. Thank you in advance for yourtime. We look forward to seeing you in the office.

1. New Patient Packet
   Consent/HIPAA/Disclosure/Financial Release
   Forms Required Government Form
2. Physician Questionnaire
3. Insurance Card and form of identification
4. Any surgical x-rays/MRI films and MRI report done within the last 6 months
5. A Copay/deductible will be collected at the time of visit. If you do not have insurance coverage, payment in full is expected prior to each visit.

Sincerely,
The staff of Howard W. Harris, M.D.

PLEASE INITIAL ALL SECTIONS, SIGN & DATE FORM

_____FINANCIAL RESPONSIBILITYAGREEMENT:

Initials

I agree to assign insurance benefits to Texas Orthopedic Specialists, PLLC. We bill all insurance companies that we are contracted with as "network" providers as a courtesy to our patients. I acknowledge full financial responsibility for services rendered by Texas Orthopedic Specialists, PLLC and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to Texas Orthopedic Specialists, PLLC. Payment is expected at the time of service. We will file your insurance as a courtesy to you. If your deductible has not been met and/or if you are responsible for a co-payment under your plan, we will expect the payment of such upon delivery of services and immediately upon the end of your visit. There will be a $30 fee for returned checks.

_____PATIENT PRIVACY PRACTICES:

Initials

We are committed to ensuring your Protected Health Information (PHI) remains confidential. Your paper and electronic medical records are safeguarded and released only with your consent or to your insurance carrier, other medical professionals directly involved with your care, or as required by law. Our "Notice of Privacy Practices" policy manual, which explains how your medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your PHI to another doctor or facility you will be required to fill out a separate form to request your records.

_____CONSENT OF TREATMENT:

Initials

I authorize Texas Orthopedic Specialists Physicians and the Physician's Assistants to evaluate and treat me or my family member for any orthopedic illness or injury for which I seek medical care. I have read and understand the above clinic polices and I further acknowledge that I accept the terms outlined in each of the above policies.

_____PHYSICIAN ASSISTANT CONSENT

Initials

This facility has on staff Certified Physician Assistants (PA-C) to assist in the delivery of orthopedic medical care. I acknowledge a Physician Assistant is not a physician. A PA-C is licensed by the state medical board and under the supervision of a physician can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does NOT require constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. A list of services may be provided that are within the scope of practice for a PA-C upon request. I hereby acknowledge the above information and consent to the services of a Certified PA for my health care needs. I understand that at any given time I can request to see the Physician instead of the PA-C.

_____PROOF AND CHANGE OF INSURANCE

Initials

Patient are required to show both proof of insurance and a Government issued photo ID at their initial and subsequent visits. The patient (parent/legal guardian) is responsible for informing our office of any changes in your insurance coverage since your last visit. Please assure that notification is made no later than 24 hours prior to your appointment to avoid having to re-schedule your appointment.

_____DISABILITY PAPERWORK/ MISSED APPOINTMENT POLICY/ RADIOLOGY AND LAB FEES

Initials

Please give all forms regarding disability to the nursing staff. Please do not give these forms to the physician. Please note that there is a $25.00 completion fee per form. You will need to expect 72 hours for these forms to be completed. Fill out the portion of the disability form that is for the patient and leave physician areas blank.

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A $50 fee may be charged for a no show or late cancellation of appointments. Payment of this fee is the responsibility of the patient and is not covered by insurance.

You may incur additional charges from providers outside of your network for procedures done outside of our facility that may be part of your surgical procedure or radiological exam. This can include pathology, radiology and/or lab fees.

ACKNOWLEDGEMENT:

- I acknowledge that I received access to the "Notice of Privacy Practices" information for Texas Orthopedic Specialists, PLLC I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize Texas Orthopedic Specialists, PLLC to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I have read and understand the "Physician's Consent" and the "Disclosure of Financial Interest"
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result of care or medical outcome.
- This authorization remains valid and effective from the date of signing until revoked in writing.

X_____ _____

Patient or Guardian Signature Date

X_____ _____

Patient or Guardian Printed Name Patient ID - Office Use Only

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Texas Orthopedic Specialists must obtain a signed authorization from the patient or the patient's legally authorized representative to electronically disclose the patient's protected health information. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Patient Name:_____ Date of Birth:_____

I HEREBY AUTHORIZE TEXAS ORTHOPEDIC SPECIALISTS TO DISCLOSE THE PATIENT'S PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSON/ORGANIZATION:

1. Person / Organization Name: _____
Address:_____
Phone:_____Fax Number_____

2. Person / Organization Name: _____
Address:_____
Phone:_____Fax Number_____

REASON FOR DISCLOSURE (Choose One): ☐Treatment / Continuing Medical Care ☐Personal Use ☐Billing orClaims ☐Insurance☐ Legal Purposes ☐Disability Determination ☐School☐ Employment ☐Other _____

WHAT INFORMATION CAN BE DISCLOSED: Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then simply check the appropriate spot:

___ All Health Information
___ Operation Reports
___ Lab Results
___ Diagnostic Test Results
___Pathology Reports
___Billing Information
___Radiology Reports/Images
___Other: _____

RIGHT TO REVOKE: I understand that I can withdraw permission at any time by giving written notice stating my intent to revoke this authorization. I understand that prior actions taken by Texas Orthopedic Specialists and other entities that had permission to access my protected health information in reliance on this authorization will not be affected by such revocation.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures by covered entities. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. In addition, I hereby authorize Texas Orthopedic Specialists to leave detailed messages for me regarding appointments, prescriptions, or any other information pertinent to my medical care, on any phone number that I have provided.

This authorization remains valid and effective from the date of signing until revoked in writing.

X_____Date:_____
Signature of Patient or Legally Authorized Representative

Printed Name of Legally Authorized Representative of Patient (if applicable): _____

If representative, specify relationship to patient:

_____Parent of Minor
_____Guardian
_____Other

Medication Policy and Disclosure of Financial Interest

Medication Refill Policy;

1. For refills on medication please call between:
   Monday - Thursday 8:30 - 4:00pm
2. Please call several days before your supply of medication runs out. This allows adequate time to have your prescription refilled, as it's important to understand this CANNOT be considered an emergency for our staff.
3. We request that you use the same pharmacy for all your prescriptions and use only one physician to obtain pain medications.

Please allow 24 hours to process a prescription refill request and understand medications are refilled on a patient by patient basis and never refilled over the weekends or after normal business hours.

Thank you in advance for acknowledging and following our simple medication policy.

_____ _____

Signature Date

Disclosure of Financial Interest:

A Texas Orthopedic Specialists, PLLC physician you are seeing may have a financial interest in the facilities listed below. The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concerns regarding this notice, please ask your physician or a member of the staff. My signature below acknowledges that I understand that my plan of care may include admission to any of the below facilities, in which Howard W. Harris, M.D., of Texas Orthopedic Specialists, PLLC has a financial interest.

_____ _____

Signature Date

Texas Health Harris Methodist Southlake Hospital 1545 E Southlake Blvd. Southlake, TX 76092 Ph. (817) 748-8700	Bear Creek Surgery Center 100 Bourland RD. Suite 110 Keller, TX 76248 Ph: (817) 518-9130
Baylor Scott & White Medical Center - Trophy Club 2850 TX-114 Trophy Club, TX 76262 Ph. (817) 837-4600	

Office Use Only: Patient ID # _____ Date:_____/_____/_____

HOWARD W.HARRIS, M.D. - PATIENT QUESTIONNAIRE

Date:_____/____/____ **Name:**_____**DOB:**_____-_____- _____

School/AT:_____ Home Phone:_____ Work:_____ Cell:_____

REFERRING DOCTOR:_____ _____

CHIEF COMPLAINT:_____

Work Related: Y☐ **N** ☐ **DATE OF INJURY/ONSET OF PAIN**: _____**HEIGHT:**_____**WEIGHT:**_____

Describe the manner in which you were injured (please include where you were when injury occurred and be as detailed as possible on how the injury occurred)**:**

_____

How often do you have the pain/discomfort: Constant / Daily / Weekly

Severity: Mild / Moderate / Intense

Please rate your pain from 1-10: While at rest: _____ With activity:_____

Since first experiencing symptoms, are you: Improving / Unchanged / Worsening

List current treatments you have tried for this complaint (medications, injections, physical therapy, surgery) and indicate whether they have helped or not. _____

_____

_____

What activity limitations have resulted from this problem? _____

Type of Pain (circle all that apply):

Aching	Burning	Constant	Diffuse	Dull	Infrequent	Pounding
Shooting	Sharp	Stabbing	Tearing	Throbbing		

What makes the pain worse? (circle all that apply):

Climbing Stairs	Prolonged Sitting	Lying Down	Standing	Routine Activities	Weather Changes
Recreational Activities	Other (please list):				

What gives you relief? (circle all that apply):

Avoiding Activities	Use of Brace	Cane	Crutches	Walker	Cold Packs
Heat	Exercising	Joint Injections	Physical Therapy		

PAST ILLNESSES (Circle all that apply):

None	DVT/Clots	Diabetes	Gastrointestinal Disease	Heart Disease
Cancer (localized - one area)	Hepatitis	HIV	Seizure Disorder	Kidney Disease
Cancer (metastatic - spread)	Lung Disease	Stroke	Rheumatoid Arthritis	Infection in Any Joint
Cholesterol	Osteoarthritis	Thyroid	High blood pressure	
Obstructive Sleep Apnea	Blood Clots	Other:		

PAST SURGERIES (List with approximate age, including all minor surgeries):

Surgery:	**Date:**	**Physician:**

FAMILY HISTORY (List the relationship of family member next to applicable health issue):

Bleeding:	Diabetes:	Amputations:	Cancer:
Tuberculosis:	Heart Disease:	Strokes:	High Blood Pressure:
Other:			

SOCIAL HISTORY:

Employer:_____ Job Description:_____
Recreational Activities/Exercise:_____
Single:_____ Married:_____ Divorced:_____ Widow:_____ No. Living Children:_____ No. of pregnancies:_____
Do you smoke: Y_____ N _____ Approx. amount/day:_____ Have you ever smoked:_____
Do you drink alcoholic beverages?: Y_____ N _____ Type:_____ Approx. amount: _____ Daily / Weekly / Monthly
Recreational Drugs:_____ Hand Dominance: Left_____ Right_____

Medication List:

Current Medications	Dosage (mg's per day)

Please list any medication ALLERGIES you have:

Allergy	Type of Reaction

Are you seeing a pain management physician? Yes No

If so who is your physician?_____

Do you have a pain management contract? Yes No

Do you have a surrogate decision maker? _____ Yes _____ No

If yes, please name:_____

Preferred Pharmacy:_____ Pharmacy Phone:_____

Do you have allergies to: Iodine_____ IV Contrast_____ Tape_____ X-ray Dye_____ Latex_____
Do you use a CPAP or Bi PAP Machine: _____Yes _____ No

Notice of Medication and Pharmacy Benefit Management Consent:
Texas Orthopedic Specialists has the permission to obtain formulary information, information about other prescriptions prescribed by other providers and/or third party pharmacy benefit payors for treatment purposes.

_____ _____

Signature **Date**

Translation Guide

	Language	Notice
1	English	Language assistance services are available at the front desk at all of our locations.
2	Spanish Espanol	Servicios de asistencia lingilfstica estan disponibles en la recepci6n en todas nuestras localidades.
3	Vietnamese Ti ng Vi t	Djch V\l h6 *trg* ng6n ngfr c6 s n tsii quay IS tan 6 tat ca cac dja diem ClJa chung t6i.
4	Chinese cj:.:it Zh6n2Wen	t'§;:::t1J-13!J & oJ'ff-ltifJ/iiT i:rr'l!l's"Jiluis。 Yiiyiin xiezhu filwu, ke yu women su6y6u weizhi de qiiintiii.
5	Korean Oi Hangug-eo	'2jOj A[.kjl::l[A::: -'j'-2.[[.£ :':: q_[j::[Oj[.A.7 .u.-E-E [-"-3.0j[.A.7 .A.f-§- "?-'.?JL[Cf. Eon-eo jiwon seobiseuneun uliui modeun wichieseo peulonteu deseukeueseo sayonghal su issseubnida.
6	Arabic '4-!_y...J ı Alearabia	u..l..L, ,.,...; ½J---i...UI 0 l..m...o.....J ı uWl..l..:> w L,.O,_j ı • l...u....ll _9-' ı;--!--'-?" ,.,...; Jl: iii 11:II Tashtamil alkhadamat ealaa khadamat almusaeadat alllughawiat fi maktab alaistiqbal fi jmye mawaqieina.
7	Urdu .9 ., J ı	c:,L,Li..,, <..J Ly wLJ..L...:> .) .l...A uLJ. .J . u--&--! y J -H d--' l...w -H '-'-'" l.1---o--'
8	Tagalog {Filipino)	Serbisyong tulong sa wika ay magagamit sa front desk sa lahat ng aming mga lokasyon.
9	French Fran9ais	Services d'assistance linguistique sont disponibles a la reception a taus nos sites.
10	Hindi Hindee	'ITT"f ı fl \? l"1d ı i'r,rr:;i'f f'TT'TT,); 1n: mi:f.'r inf 1n: ·ti·· ı Bhaasha sahaayata sevaon hamaare sthaanon ke sabhee par saamane mez par upalabdh hain.
11	Persian {Farsi) c,-'"J Li	L, cS L., uLS...., <LA.> J.) J.) u'.J cS...0..5 c:,L,.O . U"J-L.!.) J.)
12	German Deutsche	Sprachassistenzdienste sind an der Rezeption an alien Standorten zur Verfiigung.
13	Gujarati 1"i'<Lrl.1 GuiaratI	G-\.l'll 'tl.tsl'l :il.9.L-OU "'l+ll'l.l l-i.1.-i.l t,tql "-1.l<l 2 '?.H 1R G'-1.<c\C>q f9. Bha a sahaya seva'o amara sthanono badha khate phranta <;Jeska para upalabdha che.
14	Russian PycCKllH Russkiy	MepeBo,[(qecKue ycnyru rrpe,[(OCTaBJI5!IOTC5! Ha CTOHKe perucTpawm Ha Bcex Harnux Mecrnx. Perevodcheskiye uslugi predostavlyayutsya na stoyke registratsii na vsekh nashikh mestakh.
15	Japanese B;t;:i'li Nihongo	as i'li:itf.iJi-lf-1::;(.la::, ti CT)°9"'-cCT) pfi-C:, 7 o:., t--7";(.? -c: t11mL,f::f::ita::9 。 Genga shien sabisu wa, tosha no subete no basho de, furonto desuku de go rivo itadakemasu.
16	Laotian ::J'JO	ll'llJU ::J ll 'l lJ ll 'l lJ (;] o.icm_ BW'l::1'JCCJJ DJj E.l•, 2Dm1J ')tf) c, BIJS UE.l, ' 2Dlfl '.)tJJJJ 02B'.):::J 'rj'l1Jtfl, 2B'.)WOl1CS 'l.

Lav	Kanbolikan kansuanyheu phasa aemnmi yunai na thitonhab yunai thangmod khong sathanthi khongphuakhao.

DISCRIMINATION IS AGAINST THE LAW

Texas Orthopedic Specialists, P.L.L.C. (TOS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, national origin, age, disability, or sex. TOS does not exclude people or treat them differently because of race, national origin, age, disability, or sex.

TOS provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.

TOS provides free language services to people whose primary language is not English, such as information written in other languages.

Language services are available at the front desk at all of our locations.

If you believe that TOS has failed to provide these services or discriminated in another way on the basis of race, national origin, age, disability, or sex, you can file a grievance with:

- Attention: TOS's Compliance Officer
- Mailing Address: 2425 Hwy 121, Bedford, TX
- Fax: (817) 510-0059
- Email: pam@txortho.net

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, TOS's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U. S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/portal/lobby.jsf, or by mail or phone at: U. S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C., 20201. Phone 1-800-368-1019. (TDD) 1-800-537-7697.

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.