Elliott N. Wityk D.P.M.

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

Alliance
3301 Golden Triangle Blvd.
Fort Worth, TX 76177
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 your time. 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 Elliott Wityk, D.P.M.

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 or Claims ☐ 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

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

Elliott Wityk, D.P.M. - PATIENT QUESTIONNAIRE

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

School/AT:____________________ Home Phone:____________________ Work:__________________ Cell:______________________________

Primary Care Doctor:____ **Last Visit with PCP:**________________________

Who referred you: ____

SHOE SIZE: ______________________________**HEIGHT:**________________ **WEIGHT:**______________________ ____________________

____

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		High Blood Pressure	
Obstructive Sleep Apnea	Blood Clots			

*Type: I / II Dialysis: Yes / No Last HbA1C:______________ Blood Sugar this morning:____________

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

Surgery:	Date:	Physician:

FAMILY HISTORY (List the relationship of family member next to applicable heath 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:____

Do you vape? Y☐ **N**☐ **Frequency:** _______________________________

Do you see a pain management physician? Yes No If yes, physician name:___________________________________

Do you have a pain management contract? Yes No

Do you have a surrogate decision maker? Yes No If yes, please name:________________________________

Name:_____ DOB:_____

Medication List

Medication List:

Current Medications	Dosage (mg's per day)

Please list any medication ALLERGIES you have:

Allergy	Type of Reaction

Do you have allergies to: Iodine☐ IV Contrast☐ Tape/Adhesive:☐ X-ray Dye☐ Latex☐ Jewelry/Metal:☐

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.

Preferred Pharmacy:_____ Pharmacy Phone:_____

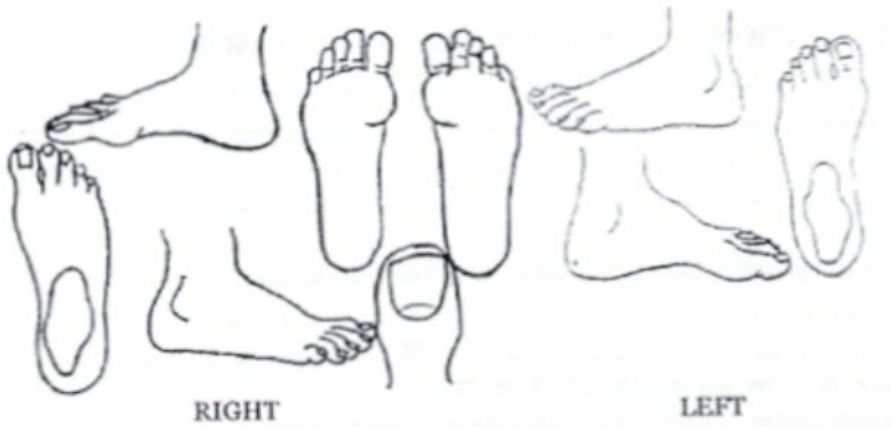
_____ _____

Signature **Date**

PAIN DIAGRAM AND PATIENT PROBLEM INFORMATION

NAME:_____ DOB:_____ DATE:_____

Please use the diagram below to indicate the location of the symptoms you are experiencing.



STAFF USE ONLY

PAIN SCALE:
LEFT: _____/10
RIGHT: _____/10

XRAYS TODAY: Y N
VIEWS: _____
PREVIOUS XR: Y N
PREVIOUS AI: Y N

REFERRAL:_____

Describe the manner in which you were injured, and/or the details of the problem(s) you wish to be seen for today. Please be as detailed as possible.

DATE OF INJURY: _____

NATURE: (sharp/dull/achy/burning/etc.) _____

LOCATION: (where is the pain/problem?) _____

DURATION: (how long have you had the problem?) _____

ONSET: (what happened? new shoes/new activity/accident):_____

COURSE: (worsening/improving/intermittent) _____

AGGREVATING FACTORS: (what makes pain/symptoms worse) _____

TREATMENTS: (what have you done for treatment already and has it helped?/seen other doctors?) :

_____

_____

_____

Translation Guide

	Language	Notice
1	English	Language assistance services are available at the front desk at all of our locations.
2	Spanish Español	Servicios de asistencia lingüística están disponibles en la recepción en todas nuestras localidades.
3	Vietnamese Tiếng Việt	Dịch vụ hỗ trợ ngôn ngữ có sẵn tại quầy lễ tân ở tất cả các địa điểm của chúng tôi.
4	Chinese 中文 Zhōngwén	语言协助服务，可于我们所有位置的前台。 Yǔyán xiézhù fúwù, kě yú wǒmen suǒyǒu wèizhì de qiántái.
5	Korean 한국어 Hangug-eo	언어 지원 서비스는 우리의 모든 위치에서 프론트 데스크에서 사용할 수 있습니다. Eon-eo jiwon seobiseuneun uliui modeun wichieseo peulonteu deseukeueseo sayonghal su issseubnida.
6	Arabic العربية Alearabia	تشتمل الخدمات على خدمات المساعدة اللغوية في مكتب الاستقبال في جميع مواقعنا. Tashtamil alkhadamat ealaa khadamat almusaeadat allughawiat fi maktab alaistiqbal fi jmye mawaqieina.
7	Urdu اردو	زبان کی مدد کی خدمات ہمارے مقامات میں سے سب پر سامنے میز پر دستیاب ہیں.
8	Tagalog (Filipino)	Serbisyong tulong sa wika ay magagamit sa front desk sa lahat ng aming mga lokasyon.
9	French Français	Services d'assistance linguistique sont disponibles à la réception à tous nos sites.
10	Hindi हिंदी Hindee	भाषा सहायता सेवाओं हमारे स्थानों के सभी पर सामने मेज़ पर उपलब्ध हैं। Bhaasha sahaayata sevaon hamaare sthaanon ke sabhee par saamane mez par upalabdh hain.
11	Persian (Farsi) فارسی	خدمات کمک زبان در میز جلو در همه مکان های ما در دسترس هستند.
12	German Deutsche	Sprachassistenzdienste sind an der Rezeption an allen Standorten zur Verfügung.
13	Gujarati ગુજરાતી Gujarātī	ભાષા સહાય સેવાઓ અમારા સ્થાનોનો બધા ખાતે ફ્રન્ટ ડેસ્ક પર ઉપલબ્ધ છે. Bhāṣā sahāya sēvā'ō amārā sthānōnō badhā khātē phranṭa ḍēska para upalabdha chē.
14	Russian Русский Russkiy	Мереводческие услуги предоставляются на стойке регистрации на всех наших местах. Perevodcheskiye uslugi predostavlyayutsya na stoyke registratsii na vsekh nashikh mestakh.
15	Japanese 日本語 Nihongo	言語支援サービスは、当社のすべての場所で、フロントデスクでご利用いただけます 。 Gengo shien sābisu wa, tōsha no subete no basho de, furonto desuku de go riyō itadakemasu.
16	Laotian ລາວ	ການບໍລິການການຊ່ວຍເຫຼືອພາສາແມ່ນມີຢູ່ໃນຫນ້າທີ່ຕ້ອນຮັບຢູ່ ໃນທັງຫມົດຂອງສະຖານທີ່ຂອງພວກເຮົາ.

	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.