MILLSAP VALLEY
ORTHOPAEDICS
& SPORTS MEDICINE

Personal and Insurance Information

Date of Injury_____ **Primary Care Physician**_____ **Work Comp Physician** _____

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Cell Phone _____ Home Phone _____ Email Address_____

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed By _____ Occupation _____

Business Address_____ Work Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified_____ Phone _____

Primary Insurance

Policy Holder for Account _____
Last Name First Name Initial

Relation to Patient_____ ***Birthdate***_____ ***Soc. Sec. #*** _____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address_____ Business Phone _____

Insurance Company _____

Identification # _____ Group # _____

Name of other dependents covered under this plan _____

Additional Insurance

Is there or could there be a liability claim for this injury? ☐Yes ☐No

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by_____ Business Phone _____

Insurance Company _____

Identification # _____ Group # _____

Name of other dependents covered under this plan _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) with any or all insurance coverage do assign directly to Donal B Rose, M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Additionally I agree to pay a 1.5% monthly interest on all unpaid balances exceeding 90 days. I understand the minimum payment due on all unpaid balances is $50 per month. Failure to pay a minimum payment may result in collection procedures. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

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Patient Medical History

Name _____ Date _____

Height _____ Weight _____

Please circle Yes/No and describe as appropriate.

Unexplained Fever, Weight Loss Y / N _____
Problems with Eyes, Ears, Nose, Mouth, Throat Y / N _____
Heart Disease or High Blood Pressure Y / N _____
Respiratory or Asthma Y / N _____
Gastrointestinal or Ulcers Y / N _____
Kidney, Bladder, or Prostate Y / N _____
Musculoskeletal, Arthritis, Lyme Disease Y / N _____
Skin or Breast Problems Y / N _____
Neurological or Psychiatric Y / N _____
Diabetes or Thyroid Y / N _____
Cancer or Blood Disease Y / N _____
Are you on disability Y / N _____
Any other medical condition _____
Last Check Up _____

Medications and Dosages _____ _____

_____ _____ _____

_____ _____ _____

Birth Control _____
Allergies and Drug Reactions _____

_____

Previous Surgery and Hospitalization with dates _____

_____

Recent Illness', Infections _____

Alcohol Usage _____ Tobacco Usage _____ Drug Usage _____
Any Diseases run in the family? _____

RATE YOUR PAIN (0-10) _____

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Acknowledgement of Receipt of HIPAA Privacy Statement as Required by Law

Millsap Valley Orthopaedics & Sports Medicine has provided me with a written explanation of how medical information about me may be used and disclosed and how I can access this information. I acknowledge that I have received and read the information provided.

_____ _____

Patient Printed Name

Patient Signature
(Parent if minor)

_____ Date: ____/____ / ____

Office Representative

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices for Donal B. Rose, MD.
I authorize this office to release my confidential health information to the following friends and/or family members: (Please list name and phone #)

_____

_____

_____

_____

Patient Signature: _____ Date: _____

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Financial Agreement

Donal "Buck" Rose, MD
924 Foster Lane
Weatherford, TX 76086
(817) 596-8200 Millsapvalley.com

***Payment**: Payment is expected in full for each appointment as services are rendered. Payment options are:
*****Cash *****Check *****Credit Card (Master Card or Visa)

***Medical Insurance**: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered" "denied". We will file your primary and secondary medical insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay a portion of the charges not covered by your insurance. If your insurance company requires a referral you are responsible for obtaining it we will file a predetermination for recommended treatment when it is requested by you.

***Missed Appointment Fee**: Our office requests 24 hours notification if you are unable to keep your scheduled appointment. If less than 24 hour notice is given, a $25.00 fee will be charged to your account. Patients with three missed appointments may be asked to transfer their records to another doctor.

***Returned Checks**: There is a fee ($30.00) for any checks returned by the bank.

***Monthly Statement**: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, and any new changes to the account, if any payments or credits applied to your account during the month. Professional fees are the responsibility of the patient, parent, or guardian authorizing treatment; we cannot send statements to other persons.

***Past Due Accounts**: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to an attorney and/or collection agency, you agree to pay all of the collections cost which are incurred.

***Divorce**: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

***Effective Date**: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

***This is an agreement between Dr. Donal "Buck" Rose, MD, an orthopedic surgeon, and the patient/debtor named on this form.*
***In this agreement the words "you" and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name for you or your child to which charges are made and payments are credited. The word "we", "us", and "our" refer to Dr. Donal "Buck" Rose, MD.*
***By executing this agreement, you are agreeing to pay for all services that are received.*

_____ _____ _____
Patient's name printed signature date

_____ _____ _____
(if patient is under 18 years old) Patent / Legal Guardian / Responsible party
_____Office Witness _____ date