PREMIER ORTHOPEDICS

KRAIG R. PEPPER D.O P.A.

6930 Harris Parkway
Suite 130
Fort Worth, Texas 76132
Phone (817)632-0020 Fax (817)632-0022

Thank you for choosing Dr. Kraig Pepper, D.O. P.A. for your care. The following is required to provide you with the quality medical care. The doctor and staff will review this information and place it in your chart.

Today's Date:

LAST NAME:	**FIRST NAME:** **MI:**
SEX (please circle): MALE FEMALE	**DATE OF BIRTH:**
SOCIAL SECURITY #:	**DRIVERS LICENSE #:**
ADDRESS:	**HOME PH:**
CITY:	**WORK PH:**
STATE: **ZIPCODE:**	**CELL PH:**
EMAIL:	**MARITAL STATUS:**

EMPLOYER:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**

RESPONSIBLE PARTY:
RELATIONSHIP:
HOME PH: **WORK PH:** **CELL PH:**

PRIMARY CARE DOCTOR:	**PHONE:**
WHO REFERRED YOU:	**PHONE:**
EMERGENCY CONACT:	**PHONE:**

Insurance Information

*****If Workers Comp, please request a claim form from the front desk. *****

PRIMARY INS CARRIER:	**POLICY HOLDER:**
POLICY ID:	**GROUP:**
RELATIONSHIP TO INSURED:	**INSURED'S EMPLOYER:**
INSURED'S SOCIAL SECURITY:	**INSURED'S DATE OF BIRTH:**

SECONDARY INS CARRIER:	**POLICY HOLDER:**
POLICY ID:	**GROUP:**
RELATIONSHIP TO INSURED:	**INSURED'S EMPLOYER:**
INSURED'S SOCIAL SECURITY:	**INSURED'S DATE OF BIRTH:**

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6930 HARRIS PARKWAY #130
FORT WORTH TEXAS 76132

Physician Assistant
Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical (may indicate specialty) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my healthcare needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Name:	Date:
Signature:	Witness: (optional)

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NEW PATIENT INTAKE FORM

PAIN:	**WEIGHT:**	**HEIGHT:**	**AGE:**
OCCUPATION:		**Primary Care Physician:**	
Do you exercise? Yes No Describe:			
What is the main reason for your visit? (Please describe below)			
Is your condition: (Please circle) Off and On Constant Progressive Chronic			
Current problem began: (Please circle) Suddenly Gradually			
Date pain began:			

How long has this been a problem? (Please circle) **Less than 2 months 2-6 months 6-12 months Greater than 1yr**
Comments Below:

Current problem is a result of a(n): (Please circle) **Injury at Work Auto Accident Sports No Apparent Cause Other:**
Have you been treated by another provider for this condition? Yes No
If yes, please list:

What treatments have you had for this problem? (Please circle) **Nothing Chiropractic Care Acupuncture Injections Physical Therapy**		
Medications for current problem: (include Muscle Relaxants, Pain Medications, anti-inflammatory agents)		

How far can you walk?

What makes the pain or symptoms worse? (Please circle) **Exercise Sitting Standing Walking Bending Forward Bending Backward** **Pushing Pulling Night Pain Specific Activity:**
What reduces your pain? (Please circle) **Nothing Lying Down Sitting Standing Walking Medication Changing Positions**

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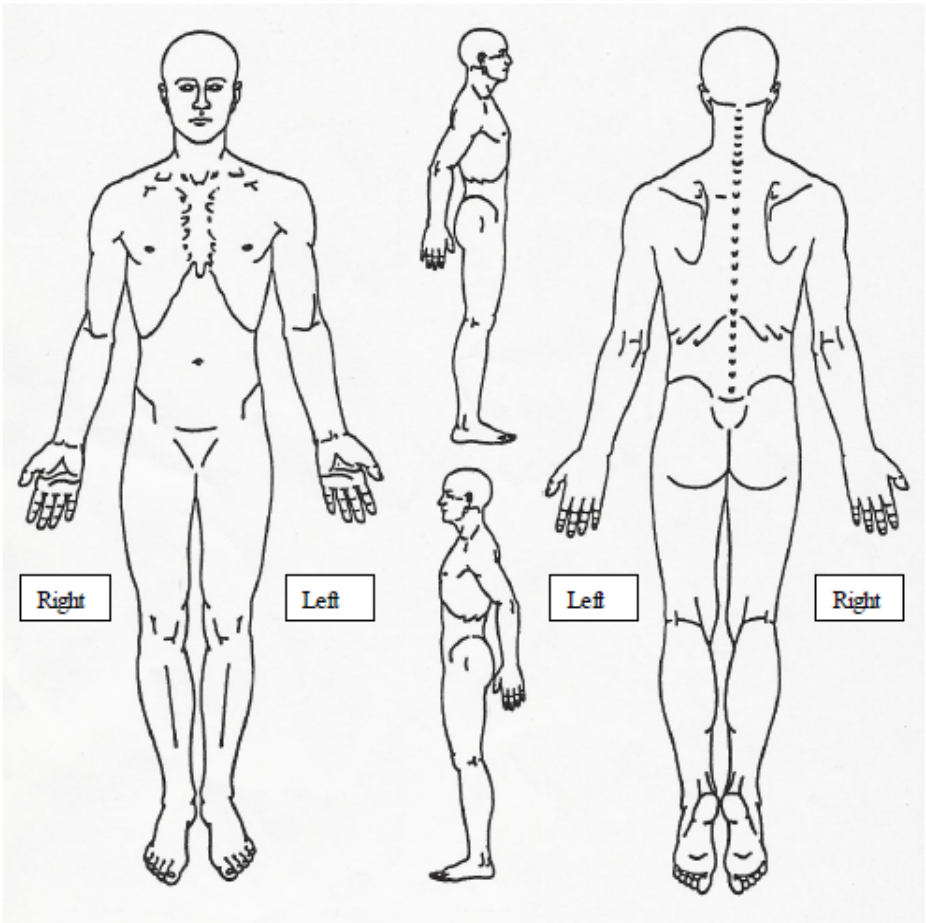
PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	Ache	B =	Burning	R =	Radiating Pain	D =	Dull Pain
N =	Numbness	S =	Stabbing	P =	Pins & Needles	O =	Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

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Past Medical History

Surgical History

Date	Surgery	Complication

Current Medical Illnesses: Please circle all that apply for Patient and Family History

Heart Disease	Pt	Fam	Stroke	Pt	Fam	Sleep Apnea	Pt	Fam
Hypertension	Pt	Fam	Arthritis	Pt	Fam	High Cholesterol	Pt	Fam
Diabetes	Pt	Fam	Gout	Pt	Fam	Headaches	Pt	Fam
GI Upset Ulcers	Pt	Fam	Emphysema	Pt	Fam	Sickle Cell	Pt	Fam
Cancer	Pt	Fam	Skin Desease	Pt	Fam	Osteoporosis	Pt	Fam
Nerve Pain	Pt	Fam	Thyroid Disease	Pt	Fam	Liver Problems	Pt	Fam
Muscle Pain	Pt	Fam	Hepatitis	Pt	Fam	Bone-Joint Problems	Pt	Fam
Mental Disorders	Pt	Fam	Tuberculosis	Pt	Fam	Epilepsy	Pt	Fam
Bleeding Disorders	Pt	Fam	Kidney/Bladder Problems	Pt	Fam			

Medication Allergies? (Please circle) Yes No
If yes, please list:
Food Allergies? (Please circle) Yes No
If yes, please list:
Allergic to Latex? (Please circle) Yes No
If yes, please describe reaction:
Problems with Anestesia? (Please circle) Yes No
If yes, please explain:

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Medication History

Medication, Dosage and Frequency of Use: (please include OTC and Herbal products)	
1.	16.
2.	17.
3.	18.
4.	19.
5.	20.
6.	21.
7.	22.
8.	23.
9.	24.
10.	25.
11.	26.
12.	27.
13.	28.
14.	29.
15.	30.

Social History

Do you smoke?	Yes	No	If yes, Packs per day ( )	How many years? ( )
Have you quit smoking?	Yes	No	If yes, How long ago? ( )	
Do you drink alcohol?	Yes	No	If yes, Please Circle: Daily Weekly Monthly Yearly	
Do you use street drugs?	Yes	No	If yes, Describe type and frequency below.	

Have you had any of the following Diagnostic Studies performed?
***** If yes, bring them to the initial visit or have them sent prior to your appointment date. *****

X-Ray	No	Yes	Where	Date
Cat Scan	No	Yes	Where	Date
Myelogram	No	Yes	Where	Date
EMG Studies	No	Yes	Where	Date
Discogram	No	Yes	Where	Date
MRI	No	Yes	Where	Date
Bone Scan	No	Yes	Where	Date
Bone Density	No	Yes	Where	Date
Other	No	Yes	Where	Date

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Patient Consent Form

Patient Name (please print):	Date:

I acknowledge I have been given an opportunity to read the Privacy Practice Policy for Dr. Kraig R. Pepper, D.O. P.A. I give my consent to release personal information for the purposes of treatment, referrals, payment, or healthcare operations. I also understand I may withdraw my consent at any time in writing.

I understand my medical records may be transmitted electronically, by fax and may be received in error by a third party. In the event this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operation and understand I may withdraw this consent at any time in writing.

I also understand I have the right to request restrictions as to how my health information may be used or disclosed.

I also understand I have the right to revoke this consent in writing, except where the practice has already made disclosures in reliance of my prior consent.

Other person(s) permitted to receive my medical records other than in paragraph one:

□ **No restrictions – may release information to anyone if requested.**

□ **Restricions; detail below:**

_____

_____

_____

I wish to be contacted in the following manner (Please check all that apply):

Home Telephone:	Cell Phone:

□ **O.K. to leave message with detailed information**

□ **Leave message with call back number only**

Other: _____

Patient/Parent (if minor) Signature: _____ **Date:** _____

Relationship, if not patient's signature: _____

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Consents and Disclosures: I hereby voluntarily agree to diagnostic procedrues, and medical and surgical treatment, which may be administered to or performed on me under the general and special instructions of the attending provider's care and service, or the provider's designee(s).

I hereby voluntarily agree to and understand, I may be followed during my Orthopedic care at Dr. Kraig R. Pepper, D.O. P.A., by a Board Certified Orthopedic Physician Assistant, designated OPA-C, during follow up visits or post operatively at the request and designation of the attending provider.

I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks.No guarantees have been made to me as to the results of my treatment at Dr. Kraig R. Pepper, D.O. P.A. I further understand that Dr. Kraig R. Pepper, D.O. P.A. encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care. (I understand any invasive procedue will be explained, and I will be asked to sign an authorization for that treatment).

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to the attending physician. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance, I herby authorize said assigned to release all information necessary to secure payment.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Note: A copy of this agreement may be used with the same effectiveness as an original.

Patient/Parent (if minor) Signature: _____ **Date:** _____

Relationship, if not patient's signature: _____

Refusal to Sign

I understand I have the right to refuse to sign this authorization, and doing so, I will assume all costs involved for my medical care. I will be responsible for full payment at each time of service. I absolve my insurance company and/or employer from and resposibility for my medical care expenses.

Patient signature: _____ **Date:** _____

Witness (to signature only): _____ **Date:** _____

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PATIENT MEDICATION CONTRACT

PLEASE CHECK :

- ☐ **I am currently enrolled in a Pain Medication Contract with Dr. _____**
- ☐ **I am not enrolled in a Pain Medication Contract**

I, _____, agree to the following rules and conditions regarding my controlled narcotic pain medication therapy.

Conditions:

1. **I will NOT use illegal substances, street drugs or abuse alcohol while taking controlled pain medication. In addition, I will NOT take pain medication prescribed for another person.**
2. **I will NOT be involved in the sell, illegal possession, diversion, or transport of controlled substances like narcotics, sleeping pills, or nerve pills.**
3. **I agree to obtain drug – screening tests, including blood alcohol levels, when my physician requests it.**
4. **I agree to obtain all prescriptions for controlled pain medications from providers at Dr. Kraig Pepper ONLY.**
5. **I agree to use only ONE pharmacy _____ Phone # _____.**
6. **I agree to have _____ as a designated person to pick up my controlled prescriptions in case I am unable. He / She will present a photo ID to verify their name at the time of pick-up.**
7. **I agree to follow up every three months or as often as deemed necessary with my physician regarding pain control and to keep all scheduled clinic appointments regarding my pain.**
8. **I agree to allow this contract to be a permanent part of my medical record and have it accessible to those providers in direct care of my condition.**
9. **I agree to allow my care providers at Dr. Kraig Pepper to communicate with other physicians and pharmacists regarding my management of pain as deemed necessary.**
10. **I certify that I am NOT pregnant. I certify that I will use appropriate measures to prevent pregnancy during the course of my treatment with controlled pain medications.**
11. **I agree to contact Dr. Kraig Pepper at 817-632-0020 the next business day if an unavoidable emergency occurs requiring a prescription of controlled pain medication, an ER visit, or an inpatient admission.**
12. **I understand that NO allowances will be made for lost prescriptions or medications.**

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13. **I agree to call 3 days in advance for refills and prescription pick up. Dr. Kraig Pepper providers will NOT refill medication after business hours or on weekends. It is required that your pharmacy call us for refill requests.**
14. **I understand this mode of treatment will be stopped if any of the following occurs:**
    a) **I give away, sell, or misuse the drugs or use other people's drugs or illegal substances**
    b) **I am noncompliant with any of the terms of this agreement**
    c) **I disrespect or harass clinic personnel**
    d) **I do not follow up regularly or as requested by my physician ***No show = No medication*****

I HAVE READ THIS AGREEMENT, UNDERSTAND IT, AND HAVE HAD ALL QUESTIONS ANSWERED TO MY SATISFACTION. I CONSENT TO THE USE OF CONTROLLED NARCOTIC PAIN MEDICATION UNDER THE TERMS OUTLINED IN THIS AGREEMENT.

Print Patient Name	**Signature**	**Date**
Witness	**Signature**	**Date**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUT HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization : In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders(Such as voicemail messages, postcards, or letters).

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. A Privacy/Contract Officer has been designated for this office. The Privacy Officer can be contacted by simply contracting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

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PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____

Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care.

Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

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Patient Name:_____

DOB:_____

Race:_____

Language:_____

Smoker: Yes No

Weight:_____

Height:_____

Blood Pressure:_____

Pulse:_____