WOODLANDS
CENTER FOR SPECIAL SURGERY

Dr. Mark Ciaglia, D.O. Dr. William Jordan, M.D. Dr. Hemali Patel, D.P.M. Dr. Amit Gupta, D.O.

Patient First Name	Middle Name	Last Name
Sex ☐ Male ☐ Female	Date of Birth	Social Security #
Home #	Cell #	Work #

Physical Address	City	State	Zip
Mailing Address (if different from physical address)	City	State	Zip

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner	Email Address

Emergency Contact # 1	Relation	Phone #
Emergency Contact # 2	Relation	Phone #

Employer Name	Employer Address

Preferred Pharmacy Info Name_____ Address_____ Phone #_____	How did you hear about us? ☐ Family/Friend ☐ Insurance ☐ Internet/Website ☐ Physician ☐ Other_____

Primary Care Physician Name	Phone #
Referring Phycisian Name	Phone #

Are you a resident at a: ☐ Skilled Nursing Facility ☐ Hospice ☐ Assisted Living Facility	
Address	Phone #

Primary Insurance Company		**Secondary** Insurance Company	
Policy/Member ID Number		Policy/Member ID Number	
Group Number		Group Number	
Subscriber Name (Policy Holder)		Subscriber Name (Policy Holder)	
Subscriber Date of Birth		Subscriber Date of Birth	
Subscriber Social Security #		Subscriber Social Security #	
Relation	Gender ☐ Male ☐ Female	Relation	Gender ☐ Male ☐ Female

Complete this Section ONLY if the patient is a minor

Responsible Party First Name	Middle Name	Last Name
Address	City	State Zip
Home #	Work #	Cell #
Sex ☐ Male ☐ Female	Date of Birth	Social Security #

Signature of Patient, or Parent, or Legal Guardian **Date**

Reason for Visit:

___Hand Problem ___Wrist Problem ___ Elbow Problem ___ Shoulder Problem

___ Hip Problem ___ Knee Problem ___ Ankle Problem ___Foot Problem

___ Other: _____

Is this an injury: ___ Yes ___ No If yes, then date of injury: _____

How did this injury happen? _____

Where did this injury occur? _____

Is this injury work related: ___ Yes ___ No If yes, will you file a WC claim ___ Yes ___ No

Past Medical History

Please check any of the following conditions you have, or have had:

___ Diabetes ___ High Blood Pressure ___ Heart Disease ___Thyroid Disease

___ Asthma ___ Blood Clots ___ Heart Attack ___ Lung Disease

___ Hepatitis ___ Rheumatoid Arthritis ___ HIV/AIDS ___Kidney Disorder

___ Reaction to Anesthesia ___ Cancer, type _____

___ Other _____

Past Surgical History

Please list date and type:

_____

_____

_____

Allergies: ___ Yes ___ No If yes, please list them:

_____

Medications:

Please list all medications that you take, including Aspirin, Vitamins and Herbals:

_____

_____

_____

Patient Signature: _____ **Date:** _____

Social History:

Do you smoke? ___ Yes ___ No If yes, how much? _____

Do you drink? ___ Yes ___ No If yes, how much? _____

Do you use drugs? ___ Yes ___ No If yes, what kind? _____

Family History:

Please check any of the following conditions that are present within your family:

___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Thyroid Disorder

___ Asthma ___ Blood Clots ___ Heart Attack ___ Lung Disease

___ Hepatitis ___ Rheumatoid Arthritis ___ HIV/AIDS ___ Kidney Disorder

___ Reaction to Anesthesia ___ Cancer, type _____

___ Other _____

Review of Symptoms:

Please check any of the following symptoms that you have had in the past 12 months:

___ Numbness in Hands ___ Night Pain ___ Tingling ___ Weakness

___ Joint Pain ___ Stiffness ___ Swelling ___ Skin Changes

___ Deformity ___ Grinding Joint ___ Locking Finger ___ Loss of Motion

___ Chest Pain ___ Dizziness ___ Abdominal Pain ___ Shortness of Breath

___ Productive Cough ___ Difficulty Urinating ___ Difficulty with Bowel Movement

___ Other _____

Please list any additional information you would like the doctor to know:

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

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Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximal allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payments for services are due at the time of services rendered. This consists of but is not limited to office visit copayments, supplies and surgical coinsurance. If the patient is a minor child, the patient's guardian requesting care will be financially responsible for all charges incurred.

As a courtesy to our patients, our office does file insurance, both primary and secondary insurance. If you do have insurance, please be advised of the following:

1. Your insurance is an agreement between you and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts.

If you do not have insurance, payment is due at the time services are rendered. If surgery is to be performed a percentage of the cost will be due prior to surgery and a payment plan can be arranged for the remaining balance.

If your insurance is workers' compensation insurance, you will not have financial responsibility toward your insurance claim **UNLESS** your claim is determined to be disputed by carrier. You or your private insurance carrier may be billed for services.

If you have an accident-related claim and your insurance denies the claim and/or sends it to a third party, you will be financially responsible for all billed charges.

I authorize the release of the medical information necessary to process any claims submitted on my behalf. I authorize payment of benefits to Woodlands Center for Special Surgery as agreed upon at the time of treatment for services rendered. I also understand that I am financially responsible for all charges not covered by my insurance carrier (s).

Patients Signature: _____ Date: _____

Medicare Only

I request that payment of authorized Medicare benefits be made on behalf to Woodlands Center For Special Surgery for any services furnished to me by that physician group. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents and information needed to determine these benefits payable to related services. I understand that my original signature represents that payment be made and authorizes the release of medical information necessary to pay the claim. My signature authorizes the release of any information to the insurer or agency shown. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patients Signature: _____ Date: _____

134 Vision Park Blvd
Suite 100
Shenandoah, TX 77384
Phone 936-242-1437 Fax 936-447-9672

9851 FM 1097 West Rd.
Suite 110
Willis, TX 77318
Phone 936-242-1437 Fax 936-228-7666

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Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional information, restrictions on the practice's use and disclosure of my personal health information or to request additional confidential treatment or communications between the Practice and myself or others.

I hereby give authorization to the following person (s) for the practice to disclose any health information including but not limited to my plan of care and billing or claims payment information.

Name/Relation: _____ # _____

Name/Relation: _____ # _____

Name/Relation: _____ # _____

Signature Date

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Woodlands Center for Special Surgery Disclosure of Physician Ownership Interest

Notice to Patients

Please carefully review this notice. In order to allow you to make fully informed decisions about your health care, the physicians of Woodlands Center for Special Surgery (the "Practice") would like to inform you that at some point during the course of your treatment, the Practice may use the following facilities.

Memorial Hermann Surgery Center Pinecroft
9305 Pinecroft Dr. Suite 200
The Woodlands, Tx 77380

Shorline Surgical Center
6701 Lake Woodlands Dr. Suite 175
The Woodlands, Texas 77382

The Practice wishes to advise you that Dr. Mark Ciaglia and/or Dr. William Jordan have a direct ownership interest in the afore mentioned facilities (Memorial Hermann Surgery Center Pinecroft, Lakeshore Surgery Center). All of the providers will make referrals to facilities based upon the best interests of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership or compensation arrangement that a physician may have with a particular surgery center. Should you at any time not want services at one of the above-mentioned facilities, let your medical provider know and you will be sent to another facility of your choosing. You, as the patient, have the right to choose an alternative facility for said procedures for any reason, provided that the physician is credentialed with your preferred facility. If you have any question concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you. This list can change based on the ownership interests of the doctors, an updated list is always on file with the Medical Office Manager and on display in our practice. By signing below, you acknowledge that you have read and fully understand this notice.

Printed Name of Patient Signature Date

Printed Name of Guardian (if applicable) Signature Date