NORTH HOUSTON ORTHOPEDICS AND SPORTS MEDICINE

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Mailing Address: P.O. Box 9969 The Woodlands, TX 77387-6939

PATIENT INFORMATION/DEMOGRAPHICS

Last name:	**First:**	**Middle:**	**Date of Birth:**	**Age:**
Address: City/State/Zip		**Social Security No.:**		
Insurance: (address claims address/phone)		**ID/Group #**		
Insurance: (address claims address/phone)		**ID/Group #**		
Home Phone:	**Cell Phone:**	**Marital Status:** ☐ Married ☐ Divorced ☐ Single ☐ Other		**Sex:** ☐ M ☐ F
Email:		**Primary Care Physician/Phone:**		
Referral Source:		**Reason for Visit:**		
In Case of Emergency: (Name of a local friend or relative)		**Relationship/Phone**		

Minor Consent (please check if applicable): I, _____, being the parent or guardian of the above listed patient do hereby request and authorize North Houston Orthopedics and Sports Medicine, its affiliates and staff to perform medically necessary services including but not limited to x-rays, administration of medication and anesthetics which are deemed advisable by the physician. Initial: _____

COMPLIANCE AND DISCLOSURE UNDER TEXAS OCCUPATIONS CODE SECTION 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) has disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he / she will receive, directly or indirectly, remuneration for referring upon my such request and exercising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Section 102.006 of Texas Occupations Code. Facility with affiliation and remuneration: Dayspring Pharmacy, Global Molecular Labs, Red Oak Surgery Center, The Woodlands Surgery Center and Houston Northwest Hospital. In addition, Dr. Navid and Dr. Mansour practice at Memorial Hermann Hospital-Woodlands, Apollo Hospital, Tomball Regional Medical Center, TOPS Surgery Center and Spring Central Hospital.

NORTH HOUSTON ORTHOPEDICS CONSENT OF CARE/FINANCIAL POLICY

Thank you for selecting North Houston Orthopedics and Sports Medicine for your healthcare needs; payment is expected at the time of service. If the patient is a minor the parent, guardian or adult accompanying the child will be financially responsible regardless of legal guardianship. **As a courtesy to you, we will bill your insurance provider however it will be your responsibility for co-payments, co-insurances and deductibles not met at the time of your visit or surgery. In addition, any referrals, authorizations or additional services such as X-rays, injections, and durable medical equipment (DME) will be your responsibility if not covered by your insurance carrier**. If a balance on your account is unpaid for 30 days your care and access to North Houston Orthopedics and Sports Medicine, our providers and/or affiliates will be subject to permanent termination. Your account may also be referred to an outside collection agency. This notice fulfills our obligation to notify you of the possibility of collection action if your account is not resolved within 30 days. Expenses incurred by North Houston Orthopedics and Sports Medicine to collect outstanding balances shall be the responsibility of the person signing this agreement.

The above information is true to the best of my knowledge. I give permission to North Houston Orthopedics and Sports Medicine and its physicians, affiliates, and medical personnel to provide medical services, including but not limited to x-rays, administration of medications, anesthetics and any treatment recommended by the physician to me/child. I authorize my insurance benefits to be paid directly to the physician and authorize North Houston Orthopedics and Sports Medicine and/or any of its affiliates to release any information required to process my claims, remit payment or secure payment for the services provided to me. I authorize North Houston Orthopedics and Sports Medicine to disclose my current and previous medical records, consultation and treatment plans, to my referring physician, other healthcare providers, and hospitals that will participate in my care. I understand that by signing this form I am seeking care until I withdraw consent to North Houston Orthopedics and Sports Medicine privacy officer in writing.

Signature: _____ Date: _____

Witness: _____Date: _____