



STERLING RIDGE
ORTHOPAEDICS &
SPORTS MEDICINE

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Keith W.V. Johnson, M.D., F.A.A.O.S.
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Eileen Wu, M.D.

“Our group is unique in that we have four Fellowship trained orthopaedic surgeons who are capable of dealing with all the musculoskeletal issues of our patients. Only at the downtown medical center, do they have specialists equal to our abilities and training in arthroscopy.”

WELCOME!

Thank you for choosing our practice to serve your medical needs. We are looking forward to seeing you soon.

We pre-register patients prior to their visit. Please complete the forms and bring them to your scheduled appointment.

If needed, directions to our office are on our web site (www.srosm.com) or you can use Yahoo’s “Maps”. Convenient parking is located at our office.

Please bring any of your X-Rays/MRI images and reports with you to the visit. Your doctor will want to see those images.

And remember, if you can’t make your appointment; call us one business day ahead so that another patient can be scheduled.

If you have questions or need more help, feel free to call our office (281-364-1122) at your convenience.

Sincerely,

The Doctors and Staff of Sterling Ridge Orthopaedics and Sports Medicine

6767 Lake Woodlands Drive
Suite F
The Woodlands, Texas 77382



Telephone: 281-364-1122
Fax: 281-210-3450
Email: admin@srosm.com

Patient Information

First	Middle	Last	
Address	City	State	Zip
Home phone	Cell phone	Work Phone	Social Security No.
Date of Birth	Sex	Marital Status	Email address
Language	Race	Ethnicity	Patient provide all info? (Y/N)
Referring Physician	Employer	Occupation	Driver License #
Emergency Contact	Emergency Phone	Relationship	
Is this workers' compensation?	Date of Injury	Name of Insurance	
Pharmacy (Name/Location/Phone No./Fax No.):			
POLICY HOLDER INFORMATION			
Name	Date of Birth	Social Security No.	
<p>Notes:</p> <p>As a courtesy, please call 24 hours before your appointment if you need to cancel.</p> <p>Please bring your completed forms with you to the appointment; <u>do not fax to our office</u></p> <p>Please be aware that if your condition is pre-existing you will be fully responsible for your bill.</p>			

****PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED****

INJURY / PAIN QUESTIONNAIRE

Date: _____

NAME: _____ SEX: M F DOB: _____ AGE: _____

Is this a work related problem? Please explain: _____

OCCUPATION: _____ IF STUDENT, NAME OF SCHOOL: _____

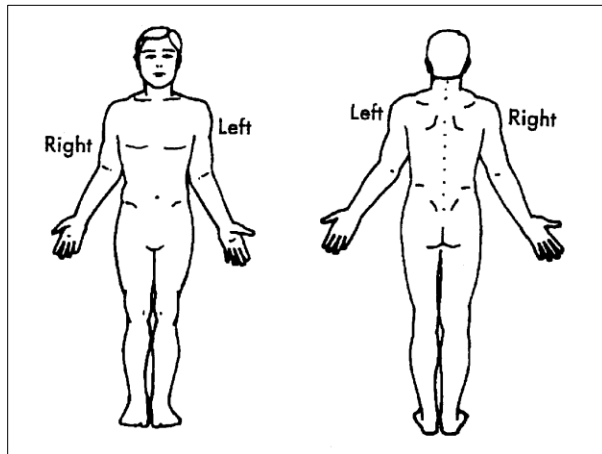
PRESENT ORTHOPAEDIC PROBLEM: _____

PLEASE DESCRIBE HOW THIS INJURY OCCURRED: _____

DATE OF INJURY: _____ REFERRING PHYSICIAN: _____

DATE OF ONSET FOR THIS PROBLEM: _____

Please indicate on the chart below where you are injured and/or where your site of pain is located:



Numbness & Tingling xxxxxxx
Pain ooooooo

Please list any known ALLERGIES TO MEDICATION:

1. _____
2. _____
3. _____

MEDICATIONS TRIED AND FAILED:

1. _____
2. _____
3. _____

Please list any current medication(s) you are taking:

1. _____
2. _____
3. _____
4. _____

1. Were you seen in an Emergency Room? Y N
Name of Clinic or Hospital: _____ Date: _____

2. Were X-rays taken? Y N

3. Has this problem been evaluated by another Physician? Y N
Name: _____ Date: _____

4. Is this a recurrent problem? Y N

5. Have you ever had surgery for this problem?
Y N If yes, please explain:
Operation performed: _____
Doctor's name: _____
Hospital name: _____

6. Do you have a history of:
Diabetes Y N
Arthritis Y N
Cardiac Conditions Y N
Elevated Blood Pressure Y N

Height _____ Weight _____

7. Other Medical Problems:

8. Have you ever had a reaction to anesthesia? Y N

9. Are you latex sensitive? Y N

10. Do you smoke cigarettes? Y N

11. Are you a recreational drug user? Y N

Patient Medical History

Height _____
Weight _____
Pulse _____

Patient Name: _____
Date: _____
Reviewed: _____ Date: _____

If you have completed this form before and there have been no changes, please check here: _____
If you have completed this form before and there have been changes, check here and mark your changes only

Past Medical History:

Have you ever had any medical problems?	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Obstructive Pulmonary Disease	Yes	No
Kidney Disease	Yes	No
Thyroid Disease	Yes	No
AIDS / HIV	Yes	No
Hepatitis	Yes	No
Rheumatoid arthritis	Yes	No

Social History:

Tobacco	Do you use:
(If yes, how much?)	Yes No
	(no. of years usage?)
Alcohol	Yes No
Do you or have you had a problem with chemical dependency?	Yes No
Are you pregnant?	Yes No

Past Surgical History:

Please list any operations you have had.

None: _____

Family History:

Has anyone in your family had any of these conditions?

Heart disease	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Bleeding disorder	Yes	No

Review of Systems:

Do you have any of these symptoms? Please circle either Yes or No for each condition.

<p>Constitutional:</p> <p>Depression Yes No</p> <p>Fever Yes No</p> <p>Weight loss/gain Yes No</p> <p>Heart:</p> <p>Chest pain Yes No</p> <p>Irregular heart beat Yes No</p> <p>Poor circulation Yes No</p> <p>Genitourinary:</p> <p>Bloody urine Yes No</p> <p>Pain on urinating Yes No</p> <p>Unable to urinate Yes No</p> <p>Neurological:</p> <p>Paralysis Yes No</p> <p>Frequent headaches Yes No</p> <p>Blood:</p> <p>Bleeding problems Yes No</p> <p>Blood transfusion Yes No</p>	<p>Eyes:</p> <p>Decreased vision Yes No</p> <p>Cataracts Yes No</p> <p>Lungs:</p> <p>Shortness of breath Yes No</p> <p>Wheezing Yes No</p> <p>Persistent cough Yes No</p> <p>Musculoskeletal:</p> <p>Joint swelling Yes No</p> <p>Muscle aches Yes No</p> <p>Joint pain Yes No</p> <p>Psychiatric:</p> <p>Depression Yes No</p> <p>Bipolar disease Yes No</p> <p>Allergies:</p> <p>Allergies to food Yes No</p> <p>Allergies to things other than medicines Yes No</p>	<p>Ears, nose & throat:</p> <p>Loss of hearing Yes No</p> <p>Sinus problems Yes No</p> <p>Gastrointestinal:</p> <p>Stomach pain Yes No</p> <p>Diarrhea Yes No</p> <p>Persistent vomiting Yes No</p> <p>Skin:</p> <p>Rash Yes No</p> <p>Dryness of skin Yes No</p> <p>Endocrine:</p> <p>Thyroid problems Yes No</p> <p>Diabetes Yes No</p> <p>Other:</p> <p>_____</p> <p>_____</p>
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Are you currently being treated for these conditions: Yes No

Office and Financial Policies

Welcome and thank you for choosing Sterling Ridge Orthopaedics and Sports Medicine for your care. We are committed to providing you with the highest quality medical care in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance will help prevent any misunderstanding or frustration at the time of your visit.

Department Information: Sterling Ridge Sports Medicine Center and Sterling Ridge MRI are departments and employees of Sterling Ridge Orthopaedics and Sports Medicine. The information contained in this document applies to each department and medical provider in the Sterling Ridge Orthopaedics and Sports Medicine practice.

No Shows and Late Cancellations: We ask that you give us the courtesy of a 24-hour advance notice if you must cancel your appointment. A NO SHOW may result in a \$50 charge to your account. Once you have two NO SHOW appointments on record, you will be required to secure any subsequent appointments with a credit card.

Insurance Requirements: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral in hand at the time of your appointment. If you do not bring your referral with you to your appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

Insurance Claim Filing/Responsibilities: We will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. You are responsible for the timely payment of your account.

Check-In: Please arrive for your appointment at least 15 minutes prior to your appointment time so that all paperwork may be completed before you are scheduled to see one of our medical providers. Please be prepared for co-pays, deductibles, and any past balances or fees for non-covered services prior to seeing your scheduled provider. Also, bring your current insurance card with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the full amount of the charges accrued for the day. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. For your convenience, we accept all major credit cards in addition to cash and check.

Late arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, we reserve the right to reschedule your appointment so that other patients are not inconvenienced.

Minors: The parent(s) or legal guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Additionally, unaccompanied minors may obtain treatment from Sterling Ridge Orthopaedics and Sports Medicine medical providers if a parent or legal guardian initials the designated space at the beginning of this section and signs the designated space at the end of this document.

Medical Records/Images: Copies of your medical records/images (MRI, X-ray) are available to you upon request at a nominal administrative charge.

Returned Goods (Durable Medical Equipment) Policy: A patient may return any brace or soft good product within five (5) days from the date of service (custom or special items are not returnable). The patient's problem may be remedied by replacing the product, adjusting the product or accepting the product for a return with a credit issued for the full amount. It may be that your insurance company may not pay for the certain services/products based on their determination of "reasonable and necessary" per your insurance company medical policies. If your insurance company determines that a particular service is not "reasonable and necessary" under your insurance company program standards, your insurance company will deny payment for that service. If you receive the service/product and this insurance non-payment occurs, you will be responsible for the amount due.

Consent to Treatment: Knowing that I have a condition requiring health care, I voluntarily authorize and consent to any and all medical treatments as may be deemed advisable by any and all Sterling Ridge Orthopaedics and Sports Medicine healthcare providers.

My initialing of each of the above policies means that I have read, understand, and agree to the office and financial policies outlined. I hereby attest that I have given and have agreed to provide current demographic and insurance information as well as authorizing the release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name: _____

DOB: _____

Responsible Person's Signature: _____

Date: _____



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PATIENT RESPONSIBILITY NOTICE

PLEASE READ THIS DOCUMENT BEFORE SIGNING

As a courtesy, our office will verify your benefits prior to your appointment.

This is not a guarantee of benefits or coverage.

If your claim is processed differently than you expected, it is your responsibility to follow up with your insurance company directly.

Thank you.

I have read the above statement and understand I will be financially responsible for all charges.

Patient or Responsible Party

Date



Sterling Ridge Orthopaedics and Sports Medicine

Patient Consent

Our “Notice of Privacy Practices and Rights of Patients” provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act.

The patient/guarantor understands:

- **Protected health information may be disclosed or used for treatment, payment or health care operations.**
- **The Practice has a “Notice of Privacy Practices and Rights of Patients” and that the patient has the opportunity to review this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Policies.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**

Patient/Guarantor Initials to acknowledge:_____

Assignment and Release

Your initials and signature acknowledges your understanding of the Patient Consent section on this form. Your signature also authorizes Sterling Ridge Orthopaedics and Sports Medicine to release medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed. “I authorize that any benefits due be paid directly to my physician. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given).”

Patient Signature

Guarantor Signature (if patient is a minor)

Date



NOTICE OF PRIVACY PRACTICES AND RIGHT OF PATIENTS

Patients' disclosures and records shall be treated with confidentiality and privacy as required by federal and state law. The patient's written permission will be obtained before their medical records are made available to anyone not directly concerned with their care. The exceptions to written permission will be for suspected abuse, neglect and public health hazards when reporting is permitted or required by law.

Uses and disclosures of health information

- Physicians and other healthcare providers providing treatment to you.
- To obtain payment for the services we provide you.
- Healthcare operations such as quality assessment, improvement activities, review of overall service and treatment, conducting training programs, accreditation, certification licensing or credentialing activities,
- Your written authorization will release your health information for treatment, payment or health care operations and can be revoked by you at any time with a written response.
- Health information can be released to family and friends for treatment, payment or healthcare operations with your authorization.
- Your information may be used to assist in the notification of (including identifying and locating) a family member, personal representative or another person responsible for your care, of your location, your general condition or death. If present you will have the opportunity to object to such uses or disclosures. In the case of incapacity or emergency circumstances, we will disclose health information based on professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. Professional judgment will also be used to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- Health information may be used to provide you with appointment reminders on postcards, letters or voicemail. Please notify us in writing if you prefer another method of notification.

The Privacy Policy is intended to provide an understanding to new policies concerning protected health information (PHI). We reserve the right to change our privacy practices and the terms of this notice at any time, provided applicable law permits such changes. Prior to making changes, a new notice will be made available upon request.

You may request a copy of our Privacy Policy Notice at any time. Additional information regarding Health Insurance Portability and Accountability Act (HIPAA) of 1996 can be found at <http://www.hhs.gov/ocr/hipaa/>.

PATIENTS RIGHTS

Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person.

Patients will have access to copies of their health information with a written request for a reasonable cost-based fee for expenses such as copies and staff time. Patient can request format and we will attempt to meet it. In the case we are unable to meet format requested, paper copies will be provided.

Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Patients have the right to request an alternative means of communication or location regarding health information. Request MUST be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Patient has the right to request a list of instances in which their health information was disclosed for purposes other than treatment, payment, healthcare operations and certain other activities beginning 4/14/2003. If request is made more than once in a twelve month period, a reasonable cost-based fee will be charged.

Information will be available to patients and staff of Sterling Ridge Orthopaedics & Sports Medicine, LLC, concerning:

1. Patient rights, including those specified in this section
2. Patient conduct and responsibilities
3. Services available
4. Provisions for after-hours and emergency care
5. Fees for services
6. Payment policies
7. Patients' right to refuse to participate in experimental research
8. Options for reporting complaints and suggestions

Information provided in advertising or marketing regarding the competence of the staff will not be misleading to patients.