Dallas Bone & Joint Clinic
Orthopaedic and Reconstructive Surgery
Phone: (214) 324-2471 | Fax: (214) 324-1734 | DallasBoneAndJoint.com

Paul D. Saadi, M.D.
Diplomate of American Board of Orthopaedic Surgery

James G. Brooks, Jr., M.D.
Diplomate of American Board of Orthopaedic Surgery

Office Information: About Your Visit

Insurance Information

We accept most major Insurance plans:
Aetna (HMO, PPO, POS), Unicare, BCBS (PPO,POS), Cigna, First Health, Medicare, Secure Horizons, United Healthcare(HMO, PPO, POS), Lumenous, Evercare, All PPO plans- "out of network benefits".

Appointments

Please call the office to make an appointment in advance. If you are unable to keep your appointment, please call us as far in advance as possible so we may use that time to see another patient in need of care. We make a sincere effort to adhere to our appointment schedule and appreciate your patience if we are late due to emergencies or hospital surgery.

Fees & Payments

We make every effort to decrease the cost of your medical care. Therefore, we request payment for all office services at the time they are rendered unless prior arrangements have been made. We accept cash, checks, MasterCard, Visa, and Discover for your convenience. If we are a participating provider of your insurance company, we will bill them. However, payment is the patient's responsibility. We will help in any way we can to assist you in handling claims.

Prescriptions & Renewals

Please request all prescriptions and authorizations for renewals between 9:00am – 4:00pm, Monday through Friday, when our full records are available. Renewals requested at other times will be filled only for extreme or emergent circumstances.

Hospital Affiliations

Dr. Brooks: Doctors Hospital
Dr. Saadi: Forest Park Medical Center, Doctors Hospital, Medical City Dallas, Park Cities Surgical Center

Last Modified: January 30, 2012

PATIENT REGISTRATION FORM

Today's date: / /

PATIENT INFORMATION

Last name: First: Middle: | Date of birth: | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( ) Mobile phone no.: ( )

City: | State: | ZIP: | Driver's License no.: State:

Occupation: | Employer: | Work phone no.: ( )

Chose/Referred to clinic by (please check one): ☐ Dr. _ _ _ _ _ | Marital status: S / M / D / W

☐ Emergency room ☐ Relative ☐ Friend ☐ Internet ☐ Other:

Email address (optional):

INSURANCE INFORMATION

Person responsible for payment and/or spouse: | Date of birth: | Age: | Sex: ☐ M ☐ F

Street address (if different): | Social Security no.: | Home phone no.: ( )

Occupation: | Employer: | Work phone no.: ( )

Work address:

Name of primary insurance co: | Name of policy holder:

Name of secondary insurance co:

Primary ID no.: | Group no.: | Medicare no.:

Secondary ID no.: | Group no.: | Patient's relation. to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Nearest relative or friend (not living with you): | Relationship to patient: | Home phone no.: ( ) Work phone no.: ( )

City: State: Zip:

Street Address (if different):

Dallas Bone & Joint Clinic
Dedicated to Restoring Active Lifestyles.

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Phone (214) 324-2471 | Fax (214) 324-1734 | www.dallasboneandjoint.com
Doctors Hospital | 9330 Poppy Drive Suite 300 | Dallas, TX 75218-3699
Forest Park Medical Center | 12222 N. Central Expwy, Ste 130 | Dallas, TX 75243

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship

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_____ _____
Additional Authorized Patient Personal Representative Relationship

_____ _____
Additional Authorized Patient Personal Representative Relationship

_____ _____
Additional Authorized Patient Personal Representative Relationship

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FINANCIAL POLICY FORM

PLEASE READ, SIGN AND RETURN TO THE RECEPTIONIST

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION SHEET"
- IF YOU ARE UNINSURED OR HAVE INSURANCE WE DO NOT ACCEPT, PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE PREVIOUSLY BEEN MADE AND AGREED UPON
- WE ACCEPT CASH, CHECKS, DISCOVER, VISA, MASTERCARD & AMERICAN EXPRESS
- REFERRALS, IF ANY ARE NECESSARY, MUST BE PRESENTED AT THE TIME OF YOUR VISIT

The fees that we charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance companies could vary greatly on the types of coverage available. You will need to check with your insurance company regarding the specific coverage you may have.

If you are an HMO patient, it is your responsibility to make sure all referral information from your primary care physician is in our office prior to your visit. We will require this referral authorization before we can render any services to you. If you do not provide-the appropriate referral information at the time of your visit and services are rendered to you, you agree to pay our doctors their billed rate as a fee-for-service patient foregoing any health care insurance coverage you may have.

If you have Medicare, we will file the claim forms representing services rendered to you as "assignment accepted."

If you have any secondary insurance, you agree to provide us with this information at the time of your visit so that we may file the appropriate claim forms for you.

All patients are responsible for paying their annual deductible balance, co-insurance payments, and any non-covered service charges at the time of your visit.

We do not accept Medicaid patients other than for emergency room services. If you are a Medicaid patient or anticipate applying for Medicaid for the payment of the services rendered to you, by signing this agreement you understand that our doctor is accepting you as a private-pay patient and not as a Medicaid patient for any non-emergent services rendered to you and that you will be responsible for paying for the non-emergent services you receive from any of our doctors. We will not file a claim to Medicaid for the non-emergent services provided to you.

I, _____ (patient or legal guardian) HAVE READ THE ABOVE INFORMATION AND FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL APPLICABLE CHARGES AT THE TIME SERVICES ARE RENDERED. I AUTHORIZE THE RELEASE OF MY MEDICAL AND BILLING INFORMATION FOR THE PURPOSE OF PAYMENT OF INSURANCE BENEFITS TO MYSELF OR TO MY PHYSICIAN. I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY.

SIGNATURE _____ DATE _____

I WILL PAY TODAY'S CHARGES WITH:

__ Personal check __ Cash __ Visa __ MasterCard __ Discover __ American Express

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MEDICAL HISTORY FORM

NAME: _____ AGE: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN: _____ PRIMARY: _____

DATE OF ACCIDENT OR ONSET OF SYMPTOMS: _____

IS THIS A WORK INJURY? ☐ IS THIS FROM AN AUTO ACCIDENT? ☐

PLEASE DESCRIBE YOUR SYMPTOMS: _____

_____

_____

_____

GENERAL MEDICAL HISTORY: (check all that apply)

☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Tuberculosis
☐ Ulcer	☐ High cholesterol	☐ Heart attack	☐ Hepatitis
☐ Asthma	☐ Thyroid disease	☐ Stroke	☐ HIV
☐ Emphysema	☐ Kidney disease	☐ Blood clots	☐ Gout
☐ Arthritis	☐ Rheumatoid arthritis	☐ Cancer, Type: _____	

☐ Other medical problems: _____

SURGERIES:

☐ Tonsillectomy	☐ Appendectomy	☐ Gall bladder	☐ Thyroid
☐ Hemorrhoids	☐ Hysterectomy	☐ Heart surgery	☐ Hernia

☐ Cancer surgery, Type: _____ ☐ Back surgery, Type: _____

☐ Joint replacement, which and when: _____

☐ Other surgeries: _____

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MEDICAL HISTORY FORM PAGE 2

MEDICATIONS:

☐ Coumadin ☐ Aspirin ☐ Prednisone ☐ Anti-inflammatory

Please list all other medications taken: (or attach a list)

ALLERGIES TO MEDICATIONS:

☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Aspirin
☐ Other : _____
☐ Do you smoke? How much? _____ ☐ Alcohol? How much? _____
☐ Pregnant? How long? _____

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PHARMACY INFORMATION

OUR OFFICE **MUST** HAVE THE FOLLOWING INFORMATION IN ORDER TO PROVIDE YOU ANY FURTHER PRESCRIPTIONS:

PATIENT'S NAME: _____

DOB: _____

PHARMACY NAME: _____

ADDRESS: _____

PHONE #: _____

ALLERGIES: _____

DATE: _____

Please contact your pharmacy for any medication refills. Your pharmacy will fax us a medication refill request which the physician will review. Please allow sufficient amount of time for us to process your refill request.