NEW PATIENT INFORMATION

Please help us help you by answering the following questions as accurately as possible.

BOX – FOR OFFICE USE ONLY

Primary Care Physician: _____	Fax: _____
Referring Physician: _____	Fax: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ILLNESS

What problem (pain or injury) did your doctor refer your for? _____

_____

DURATION: How long have you had the pain or injury (weeks, months, years)? _____

FREQUENCY: How many days a week do you have pain? _____

ONSET: Did the pain start _____ suddenly or _____ gradually?

MODIFYING FACTORS: Was there an accident or incident that first caused the injury? ____ No ____ Yes

If YES, please describe: _____

_____

TIMING: Is the pain or injury _____ constant or _____ intermittent?

QUALITY: How would you describe the pain? ____ Burning _____ Stabbing _____ Aching ____ Other

If OTHER, please describe: _____

_____

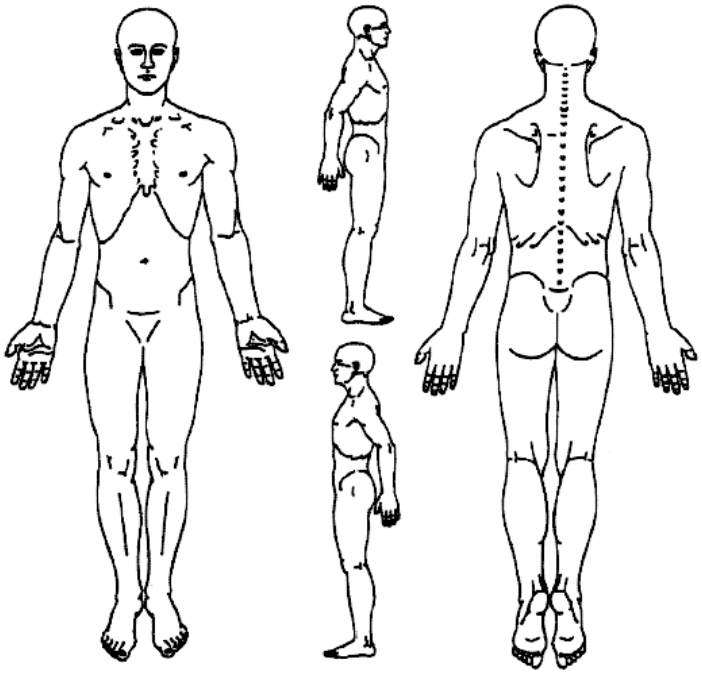
SEVERITY: Please rate your pain with "0" = NO PAIN and "10" = PAIN REQUIRING **IMMEDIATE** ER VISIT

How severe is the pain at its least (circle one)? 0 1 2 3 4 5 6 7 8 9 10

How severe is the pain at its worst (circle one)? 0 1 2 3 4 5 6 7 8 9 10

At what level of pain do you need medication (circle one)? 0 1 2 3 4 5 6 7 8 9 10

LOCATION: Where is your pain located (please mark the area(s) of your pain with an "X" below)?



What is your weight? _____ Lbs. & What is your age? _____

MODIFYING FACTORS:

What (if anything) reduces the pain? _____

What (if anything) makes the pain worse? _____

ASSOCIATED SIGNS/SYMPTOMS: Do you have any other symptoms related to your pain or injury that you want us to know about? _____ No _____ Yes

If YES, please explain: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT OTHER SYMPTOMS YOUR MAY HAVE

CONSTITUTIONAL: Do you have fevers on a regular basis (temperature of 101° or more on thermometer)? _____ No _____ Yes

Have you had any unintentional weight loss (greater than 15lbs)? _____ No _____ Yes

PSYCH: Does your pain or injury cause you to feel sad or depressed on a regular basis? ____ No ____ Yes

If YES, please explain: _____

HEME: Do you have problems with your blood clotting or have low platelets? _____ No _____ Yes

If YES, please explain: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past or present medical conditions

_____ Diabetes
_____ High Blood Pressure
_____ High Cholesterol
_____ Stroke
_____ Heart Disease or Heart Attack
_____ Aneurysm
_____ Tuberculosis
_____ Hepatitis
_____ AIDS or HIV
_____ Cancer (if yes, what type)
_____ Gout
_____ Kidney Disease
_____ Bleeding Ulcers
_____ Uveitis
_____ Glaucoma
_____ Rheumatoid Arthritis
_____ Other Medical Problems
_____
_____
_____
_____
_____

Please list any ORTHOPAEDIC SURGERIES you have had

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

Please list any JOINT or SPINAL INJECTIONS you have had

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

Please list any OTHER SURGERIES you have had

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

Are you allergic to any medication? _____ No _____ Yes

If YES, please list medication(s) and reaction(s): _____

_____

Please list ALL medications you currently take (if necessary, use back for additional space)

Medicine	Dose	How many times daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any of the following?

Aspirin _____ No _____ Yes
Plavix _____ No _____ Yes
Warfarin (Coumadin) _____ No _____ Yes

PLEASE ANSWER THE FOLLOWING ABOUT YOUR SOCIAL HISTORY

Do you **CURRENTLY** smoke? _____ No _____ Yes

If YES, how many packs per day? _____

For how many years? _____

If you don't currently smoke, did you smoke in the past?_____ No _____ Yes

If YES, how long ago did you quit? _____ No _____ Yes

Before you quit, how many packs per day did you smoke? _____

Before you quit, how many years did you smoke? _____

Do you **CURRENTLY** drink alcohol? _____ No _____ Yes

If YES, how many days per week? _____

How many drinks do you have when you drink? _____

Do you **CURRENTLY** use any of the following recreational drugs?

Marijuana _____ No _____ Yes
Cocaine _____ No _____ Yes
Speed or Amphetamines _____ No _____ Yes
Heroin/Opium/Morphine _____ No _____ Yes
Designer Drugs _____ No _____ Yes
Other _____

Have you **EVER** used any of the following recreational drugs?

Marijuana _____ No _____ Yes
Cocaine _____ No _____ Yes
Speed or Amphetamines _____ No _____ Yes
Heroin/Opium/Morphine _____ No _____ Yes
Designer Drugs _____ No _____ Yes
Other _____

Are you CURRENTLY _____ Married _____ Single _____Divorced?

How many children do you have? _____

What are their ages? _____

Do you CURRENTLY work? _____ No _____ Yes

Where? _____

What do you do? _____

For how long? _____

If you currently work, how would you describe your job satisfaction?

_____ I love my job

_____ I like my job

_____ I go to work because I have to

_____ I usually dislike my job

_____ I hate my job

If you don't currently work, how long have you been out of work? _____

Is this related to your pain or injury? _____ No _____ Yes

Are you presently receiving DISABILITY benefits? _____ No _____ Yes

Have you EVER filed a claim under workers' compensation? _____ No _____ Yes

Are you currently involved in ANY litigation due to your pain or injury? _____ No _____Yes

Is this related to your pain or injury? _____ No _____ Yes

Have you EVER been a victim of any of the following?

Emotional abuse	_____ No	_____Yes, how long ago _____
Physical abuse	_____ No	_____Yes, how long ago _____
Sexual abuse	_____ No	_____Yes, how long ago _____

I understand that for my doctor to provide me with the best possible care, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

_____ _____ / _____ / _____

Patient Signature Date

*****IF YOU HAVE ANY MRIs, X-RAYs, CT SCANS, REPORTS & FILMS, EMGs, LABS OR CLINICAL NOTES PERTINENT TO YOUR OFFICE VISIT, PLEASE BRING THEM WITH YOU*****

Patient Registration Information

Please PRINT and COMPLETE ALL sections below

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PATIENT'S PERSONAL INFORMATION Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Name: (Last)_____ (First)_____ (Middle Initial)____

Street Address: _____ (Apt. #: _____) City: _____ State: _____ Zip: _____

Home Phone: (____) _____Work Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: _____/_____/_____ Driver's Lic.: (State & #) _____ SSN: _____-_____-_____

Email: _____@_____.com

Emergency Contact: _____ Cell Phone: (____) _____ Relationship: _____

PATIENT CERTIFICATION OF FEDERAL OR STATE GOVERMENTAL INSURANCE COVERAGE

(Medicare, Medicaid, Tricare)

Patient Name: _____

☐ I hereby certify that I do NOT have coverage under Medicare, Medicaid, Tricare, or other federal or state program. I understand that failing to disclose this to my medical provider or misrepresenting my coverage may have legal consequences.

☐ I have Medicare, Medicaid, Tricare (CIRCLE ALL THAT APPLY)

Signature: _____

Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Steven Simmons, D.O., PLLC and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by any type of insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I understand an account in default may be referred to a collection agency. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Your Signature: _____ Date: _____

Steven Simmons, D.O.
Jeffery Hawkins, M.D.

Robert Menzies, M.D.
Mark Garza, M.D.

CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that I am personally responsible for payment for anything that insurance may not cover including, but not limited to, recommended medical services such as preventative health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, and preparation of reports, form, and summaries.

I have read and fully understand the above consent for treatment and financial responsibility. This authorization shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ Date: _____

PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the HIPAA Notice of Privacy and Practices and Nondiscrimination Statement which explains how my medical information will be used and disclosed.

Patient Signature: _____ Date: _____

CONSENT TO CORRESPONDENCE

I consent to receive health notifications, appointment correspondence, announcements, and billing via email and portal access.

Patient Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Steven Simmons, D.O.
Address 7148 Trail Lake Drive
City Fort Worth State TX Zip Code 76123
Phone (817) 294-0934 Fax (817) 294-1488

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)
Southwest Sports and Spine Center; Steven Simmons, DO, PLLC; Robert D. Menzies, MD, PLLC
Mark Garza, MD, PLLC; Interventional Consultants of Texas, PLLC

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my

refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy

SOUTHWEST SPORTS AND SPINE CENTER

I _____ agree that in return for the services provided by Steven Simmons, DO, PLLC I will pay my/the account at the time service is rendered or will make financial arrangements satisfactory to Steven Simmons, DO, PLLC. If co-payments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Steven Simmons, DO, PLLC. All co-payments and past due amounts are to be paid at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency.

NON-COVERED SERVICES

I understand that Steven Simmons, DO, PLLC contracts with heal care service plan(s) (i.e. HMO, PPO, etc.)) that relate only to items and services which are "covered" by health care service plans. Accordingly, the undersigned accepts full personal responsibility for all items or services, which are determined by the health care service plans to not be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan, or in the benefit summary the health care plan furnished to the patient.

HMO REFERRALS

If your insurance has designated a primary care physician (PCP) it is your responsibility and/or your PCP's to provide an authorization to see a specialist. Therefore, it is understood by you, the patient, that a prior authorization from your PCP for an office visit is required. If the authorization is not provided, whether by yourself or through your insurance carrier or your PCP, you will be asked to either reschedule your appointment or pay for the full visit at the time of service and you file to your insurance carrier.

SELF-PAY ACCOUNTS

Self-pay accounts are patient who are covered by carriers that the practice does not participate in or patients without insurance at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service based on current charge schedule in effect.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate are considered "out-of-network" plans and will be required to pay the co-pay and/or visit in full at the time of service.

IF YOUR REQUIRE A PROCEDURE/SURGERY

If you require a procedure/surgery your physician/pre-cert staff will work with you to select a date that will accommodate your schedule. Also, one of our staff will review any anticipated financial responsibilities you will have. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care and this payment will be due before the procedure/surgery is performed. Please feel free to talk to our staff about payment plans if you have a special financial situation. Allow our office to work with you to ensure you are able to be provided quality care.

RETURNED CHECKS

All returned checks will incur a $35.00 fee.

COPAYS & DEDUCTIBLES

All copays and deductibles are due at time of service. Your insurance requires you to pay your portion due, which is on your insurance card. If you cannot pay at the time of service you will be rescheduled.

PATIENT PAYMENT PLANS

Steven Simmons, DO, PLLC has the ability to provide a payment agreement to any patient that is unable to pay their bill/balance in full. Please ask to speak with our Practice Manager to provide you with the terms and payment arrangements you may qualify to receive.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____ _____

Driver's License # of Responsible Party State SS # of Responsible Party

Steven Simmons, DO
Jeffery Hawkins, MD

Robert Menzies, MD
Mark Garza, MD

Dear Patient:

Our office has a fee for No Show and No Call Appointments. We require a 24-hour notice to our office to cancel or reschedule your appointment. A $50.00 fee will be required and needs to be paid in cash on your next office visit. This will be a separate payment from your normal office co-pay or coinsurance payment.

The purpose of this fee is to encourage our patients to be responsible and appreciate that this time is reserved for you and it is your responsibility to call and cancel or reschedule your appointment. We always have patients that need to come in for urgent visits and we need to keep available appointments open for these patients.

We understand that we all have emergency situations, and these will be considered based on the situation and a decision regarding the fee will be made by our office.

Thank you for your understanding and cooperation.

_____ _____

Patient Signature Date

Steven Simmons, DO
Jeffery Hawkins, MD

Robert Menzies, MD
Mark Garza, MD

In order for Steven Simmons, DO to provide me with healthcare, I consent and acknowledge that Steven Simmons, DO may contact any current or prior physician, pharmacy, or other provider who has prescribed to me or dispensed any controlled substance(s) within the last 12 months. Additionally, my primary care physician and referring physician will be provided with the clinical notes on my treatments and office visits from Steven Simmons, DO. As required, I consent to necessary medical treatment as recommended by my physician. I understand that I am personally responsible for payment for anything that insurance may not cover, including all recommended medical services, such as preventative health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, and preparation of reports, forms, and summaries. From time to time, Dr. Steven Simmons may need to communicate with me and as such I consent to receive health notifications, appointment correspondence, announcements, and billing notifications through email, text, and website portal access.

As a new patient, submitting preliminary healthcare or insurance information and/or completing new patient paperwork or making a new patient appointment with Steven Simmons, DO does not establish a physician-patient relationship. That relationship is not established until Steven Simmons, DO has completed a preliminary evaluation and then notifies the individual that he or she has been accepted as a patient.

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services. I have been offered a copy of Dr. Simmons' HIPAA Notice of Privacy Practices and Nondiscrimination Statement, which explains how my medical information may be used and disclosed.

Dr. Simmons has ownership and/or management interest in certain facilities which they may refer me to for treatment and procedures. These facilities include: USMD Fort Worth, Select Ambulatory Surgery Center of Fort Worth, I-35 Capital Mansfield, LP, Salutaris Healthcare, LLC, Interventional Consultants of Texas, PLLC, Robert D. Menzies, PLLC, Steven Simmons, DO, PLLC, Mark Garza, MD, PLLC, and DBC physical therapy.

I have read the above consents, acknowledgements and disclosures related to Steven Simmons, DO.

_____	_____	_____
Patient Name	Patient Signature	Date