ORTHOPAEDICS
Kevin Vanden Berge, MD
351 E. Tarleton St.
Stephenville, TX 76401
(254) 968-0292

Due to Health Insurance Portability and Accountability Act (HIPAA) of 1996, which requires appropriate precautions to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.

The following information must be filled out by each patient annually.

Patient Name: ______________________________ Date: ____________________

I authorize VB Orthopaedics, PA, to release my medical records or insurance information that may be necessary to process my medical condition and coordinate or manage my healthcare.

In the event a family member or caregiver attend my office visit in the exam room at the time of any evaluation and/or treatment, I give employees of VB Orthopaedics, PA my permission to discuss freely my condition, treatment, or diagnosis.

May we leave a message for appointments, lab and/ or x-ray results at:

With whom may we discuss or release information about your care, treatment, bill and diagnosis? (i.e. family member/friend)

Name	Relationship	Phone #

RELEASE OF INFORMATION: I have reviewed this office's notice of HIPAA Privacy Practices, which explains how my medical information will be used and disclosed.

Signature: ____ Date: ________________

Patient or Legal Guardian
(Signature is valid for one year from date shown)

Printed Name: ______________________________

Relationship to patient: ______________________________

AUTHORIZATION, CONSENT, AND AGREEMENT

I hereby voluntarily consent to outpatient care at the office of VB Orthopaedics, encompassing routine diagnostic procedures, examinations and medical treatment including taking of X-rays and administrations of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by VB Orthopaedics, assistants, or designees as is necessary in the medical staff's judgement.

I hereby authorize my insurance carrier(s) to pay directly to VB Orthopaedics, all benefits due me, if any, by reason of surgery or involved fracture care, or such services as agreed described in the statement rendered and as provided for in the policy contract with my insurance carrier(s). I understand that I am responsible for health insurance deductibles and coinsurance.

I HAVE READ THE AUTHROIXATIONS, CONSENTS, AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOEV. THE AUTHORIZATION SHALL BE VALID UNTIL REVOKE IN WRITING BY THE PATIENT.

Signature of Patient/Legal Guardian: ____Date: _________

FINANCIAL AGREEMENT

I agree to pay for services rendered. If applicable, I agree to pay for my co-payment at the time of service and I understand that I will be fully responsible for any services deemed as non-covered or denies by my insurance company. I also understand that there may be a patient responsibility balance even after my insurance company has made a payment.

I agree to comply quickly with any request buy my insurance company or VB Orthopaedics to assist in quick and efficient payment of my medical claims.

I accept that it is my responsibility to understand and verify that VB Orthopaedics is in network with my insurance plan including any facilities that I may be referred to for surgery, physical therapy, further testing, and/or other types of ancillary services.

If my insurance company requires a referral to see a specialist, I agree to be ultimately responsible for obtaining my referral, along with the assistance of a representative from the specialist's office. Payment can be made in the form of cash, verifiable check, and or credit card. <u>There will be a $25.00 check charge for all returned checks as having non-sufficient funds.</u>

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below. Further, I assign insurance benefits for all services rendered by VB Orthopaedics, PA. Additionally, I agree to release all such medical information as may be necessary to assist in payment of medical claims.

Signature of Patient/Legal Guardian: ____Date: _________

VB

VB Orthopaedics
Patient Information Form

D.O.B: ☐

Height: ☐

Weight: ☐

Name: ☐

Review of Symptoms: Are you currently having problems with the following? (Check all that may apply)

- ☐ Fever
- ☐ Chills
- ☐ Weakness Weight Loss
- ☐ Weight Gain
- ☐ Height Loss
- ☐ Loss of Appetite
- ☐ Glasses
- ☐ Blurred Vision
- ☐ Headache
- ☐ Easy Bruising
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Ankle Swelling
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Change in Bowels
- ☐ Bowel Incontinence
- ☐ Blood in Stools
- ☐ Frequent Urination
- ☐ Bladder Incontinence
- ☐ Blood in Urine
- ☐ Fainting/Dizziness
- ☐ Numbness/Tingling

Past Medical History: (Check all that may apply)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heartburn
- ☐ Cancer (what type)
- ☐ Dementia
- ☐ Migraines
- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Heart Murmur
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrillation
- ☐ Peripheral Vascular Disease
- ☐ Deep Vein Thrombosis
- ☐ Blood Transfusion
- ☐ Asthma
- ☐ COPD
- ☐ Bowel Irregularity
- ☐ Kidney Disease
- ☐ Bladder Problems
- ☐ Prostate Problems
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other medical problems not listed:

Surgical History: (Check all that may apply)

- ☐ Fracture Fixation
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Back Surgery
- ☐ Neck Surgery
- ☐ Carpal Tunnel
- ☐ Cardia Stents
- ☐ CABG
- ☐ Pacemaker
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Hysterectomy
- ☐ Tonsillectomy
- ☐ Other surgeries:

Family History: (Check all that may apply)

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Mental Illness
- ☐ Other family history:

Social History: (Check all that may apply)

- ☐ Married
- ☐ Single
- ☐ Children (if yes how many?)
- ☐ Occupation
- ☐ Drink Alcohol (if yes, how much?)
- ☐ Smoke (if yes, how many packs?)
- ☐ Smokeless Tobacco
- ☐ Substance or Drug Abuse

Allergies: List all allergies to medications

Meds: List the name, strength (mg) and frequency

NEW PATIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY) DATE ________

INJURY OR PROBLEM	LEFT OR RIGHT	DATE OF INJURY

PATIENT'S NAME	SEX ◉ M ○ F	MARITAL STATUS ◉ S ○ M ○ OTHER	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

MAILING ADDRESS	CITY AND STATE	ZIP CODE

PRIMARY PHONE #	HAVE YOU HAD X-RAYS FOR CURRENT PROBLEM? WHERE AT? WHEN TAKEN?

EMAIL ADDRESS	PATIENT'S EMPLOYER	WORK #

SPOUSE'S NAME	PRIMARY NUMBER	DATE OF BIRTH

FAMILY DOCTOR	HIS/HER #

IF THE PATIENT IS A MINOR OR STUDENT

FATHER	STREET ADDRESS, CITY, STATE, AND ZIP	PRIMARY PHONE #
DATE OF BIRTH	SOCIAL SECURITY #	BUS. PHONE #
MOTHER	STREET ADDRESS, CITY, STATE, AND ZIP	PRIMARY PHONE #
DATE OF BIRTH	SOCIAL SECURITY #	BUS. PHONE #

EMERGENCY CONTACT

NAME:______________________ PHONE #:________________ RELATIONSHIP:__________________

NAME:______________________ PHONE #:________________ RELATIONSHIP:__________________

INSURANCE INFORMATION

POLICY HOLDER NAME	STREET ADDRESS, CITY, STATE, AND ZIP	DATE OF BIRTH
INSURANCE CO. NAME	POLICY #	GROUP #

****NO INSURANCE COVERAGE****

PAYMENT FOR OFFICE VISITS, X-RAYS OR OTHER SERVICES ARE DUE AT THE TIME OF SERVICE

ORTHOPAEDICS
Kevin Vanden Berge, MD
351 E. Tarleton St.
PO Box 2576
Stephenville, TX 76401
(254) 968-0292
888-289-1607 (fax)

Authorization To Obtain/Release Information

Patient's Name: ____
Date of Birth:__________________ Social Security #:____________________
Address:____

I authorize VB Orthopaedics to obtain/release my medical information.

☐ I hereby request that my medical records be released to:

Dr. Kevin Vanden Berge, MD
VB Orthopaedics
351 E. Tarleton St
Stephenville, TX 76401
Phone: (254) 968-0292
Fax: (888) 289-1607

☐ I hereby authorize VB Orthopaedics to release my medical records to:

____
____
____

____
Patient/guardian signature

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIC WRITTEN AURTHORIZATION OF THE PERSON TO WHOM IT PRETAINS.