ACCIDENT DETAILS FORM
(please fill out completely & sign below)

Patient Name ______________________ Today's Date ______________________

Insured Name ______________________ Insured's Relationship To Patient (circle)

Insured SS# ______________________ Self Spouse Parent Other

1) Is today's visit related to an accident or injury? YES NO
(If answer to above is "NO", please skip to Section 2 below)

Auto Accident? Yes No State __________

Did the accident or injury happen while you were working? Yes No

Date accident/injury occurred: ______________________________

Place accident/injury occurred: ______________________________

Give details of accident/injury ______________________________

____

____

2) If today's visit is NOT related to an accident or injury:

Approximate date first symptoms began: ___________________________

Is this problem related to your work? Yes No

If so, have you reported this to your employer? Yes No

Give details of your symptoms: ______________________________

____

____

______________________________ ______________________________
Signature **Relationship to Patient**

Cypress Orthopedics, Sports & Spine
11325 Fallbrook
Houston, TX 77065
281.890.7773

Robert. S. Bell, M.D.
Pierre Le Baud, M.D.

Cypress Orthopedics, Sports & Spine
1,1325 Fallbrook
Houston, TX 77065
281 890 7773

Robert S. Bell, M.D
Pierre Le Baud, M.D

NEW PATIENT INFORMATION

(Please Print)

Date: ______________________

PATIENT: THIS SECTION REFERS TO PATIENT ONLY

(Rev. 01.14.13)

NAME ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

HOME PH# ______________________

CELL# ____________ ~~PGR #~~ ____________

SS# ____________ TX DL# ____________

DATE OF BIRTH ____________ SEX ________

MARITAL STATUS ______________________

EMPLOYER ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

WORK PH# ______________________

INSURED'S INFORMATION

NAME ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

HOME PH# ______________________

DATE OF BIRTH ______________________

SS# ____________ TX DL# ____________

RELATIONSHIP TO PATIENT: (please circle one)

SELF SPOUSE PARENT OTHER

EMPLOYER ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

WORK PH# ______________________

INSURANCE CO ______________________

INSURANCE CO PH# ______________________

INSURED'S ID# ______________________

GROUP # ______________________

RESPONSIBLE PARTY INFORMATION
(if different from above)

NAME ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

HOME PH# ______________________

DATE OF BIRTH ______________________

SS# ____________ TX DL# ____________

EMPLOYER ______________________

ADDRESS ______________________

CITY ______________________

STATE ____________ ZIP ____________

WORK PH# ______________________

RELATIONSHIP TO PATIENT: ______________________

CONSENT AND ACKNOWLEGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

Cypress Orthopedics, Sports & Spine
11325 Fallbrook
Houston, TX 77065
281-890-7773

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Cypress Orthopedics, Sports & Spine of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____________________________

Signature: ________________________________

Relationship to Patient: ____________________

Date: ____________________________________

Authorization for Treatment
I do hereby authorize treatment and or services to be rendered by Cypress Orthopedics. I understand that the legal guardian must authorize treatment for a minor child or socially dependent person.

Medicare
I request that payment of authorized Medicare benefits be made on my behalf to Robert S. Bell, M.D. / Pierre Le Baud, M.D. / Kimberlea W. Staton, M.D. / Susan K. Herdman, P.A.-C (Cypress Orthopedics) for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under the Title XVIII of the Social Security Act.

Insurance Company
I hereby authorize release of information necessary to file a claim with my insurance company and Assign Benefits otherwise payable to me to the doctor or group indicated on the claim.

Work Comp.
I hereby authorize release of information necessary for this service to my work comp carrier and or my employer on record. I understand that in the event these services become noncompensible that I am responsible for all services in full.

Letters of Protection
In the event that my physician has accepted a Letter of Protection from my attorney, and my attorney withdraws from my case at a later date, I hereby agree that I will be responsible for any and all charges incurred.

Financial Policy
We are pleased to file your insurance claim. It is our best effort to verify coverage and benefits before you arrive at our office. Payment is due at the time of service for any applicable co-pays, advised deductible, coinsurance and/or non-covered services. Should there be any additional patient responsibility after insurance response, we will expect payment from you within 30 days of receipt of statement. If for any reason you are unable to meet your financial obligation in full, please contact our Billing/Collections Department immediately to discuss payment options. If you receive a joint injection or fracture care today or at any future date of service, please be advised the American Medical Association classifies these injections as well as other specific office procedures as office surgery. Depending on the benefits of your insurance plan, these charges may be applied to a deductible and you will be responsible for payment.

It is not uncommon for insurance companies to pend claims due to a request for information from the insured regarding accident details, a completed claim form, student status or other insurance coverage. If your insurance company requests information from you in reference to our claim, it is your responsibility to respond immediately to release payment. If you do not respond to your insurance company's request for further information, we will bill you and you will be responsible for all charges incurred.

Third Party, Automobile Liability or PIP Insurance
We do not accept third party, automobile liability or PIP insurance. If your injury is due to a motor vehicle accident or an accident involving a third party, we will file your claim to your medical insurance. If the claim is denied, you will be responsible for payment in full. If you do not wish to file a claim with your medical insurance, you will be responsible for payment in full at time of service.

I agree to the above-mentioned statements. I certify that the information given on this form to be true and correct.

______________________	______________________
Printed Name	Signature
______________________	______________________
Relationship to Patient	Date

Rev. 01.14.13

CYPRESS ORTHOPEDICS, SPORTS & SPINE

DIPLOMATES AMERICAN BOARD OF ORTHOPAEDIC SURGERY

ROBERT S. BELL, M.D.
PIERRE LE BAUD, M.D.

Patient's Authorization to Release Medical Information

I understand that my family members and/or friends may ask questions about my medical condition over the telephone or in person. I also understand it is a breech of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Cypress Orthopedics, Sports & Spine to be able to discuss my medical condition. I understand this form will be updated every calendar year. I understand I have the right to revoke this authorization, in writing, at any time.

In the case of divorce, both parents of a minor child will be considered to have the right to access records, consult with the physician and authorize treatment not involving invasive procedures. A copy of the court order specifying otherwise will be required.

In accordance with the above, I hereby authorize Cypress Orthopedics, Sports & Spine to discuss with and release my medical and/or billing information to the following individuals: *(please print)*

__________________________ __________________________

__________________________ __________________________

The following individuals are authorized to pick up any written prescriptions, x-ray films, medical and/or billing records on my behalf. *Check here if same as above* O

__________________________ __________________________

__________________________ __________________________

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above individual/s, I must designate it here by stating what information is to be excluded:

____

Patient (or Guardian) Signature: ______________________ Date: __________

Patient Name (please print): ________________________________

01.14.13

NEW PATIENT MEDICAL INFORMATION

THIS FORM REFERS TO THE PATIENT ONLY

(Please print)

Patient Name ______________________ Date of Birth ____________ Today's Date ____________

Male ______ Female ______ WHO REFERRED YOU? ______________ FAMILY DR. ______________

PERSON TO CONTACT IN CASE OF EMERGENCY ______________________ PH# ______________

CURRENT MEDICATIONS	ALLERGIES TO DRUGS/MEDICATIONS (Please state if none)
____________________	____________________
____________________	____________________
____________________	____________________

BRIEF MEDICAL HISTORY ____

____

PREVIOUS SURGERIES ____

____

PRESENT COMPLAINT OR HISTORY OF INJURY ____

____

____

(See Reverse Side)

OFFICE USE ONLY: W/C REG. INS. OTHER DOI ____________

HT ________ WT ________ B/P ________ PULSE ________ RESPIRATION ________

REFERRING DR. ______________________ ARE WE NOW TREATING: YES NO

TREATMENT ALREADY RECEIVED BY REFERRING DR.: PT ________ MEDS ______________

INJECTIONS ________ OTHER ______________________

PRESENT WORK STATUS: LIGHT REGULAR OFF OTHER ______________

TYPE OF WORK ______________________ TIME W/PRESENT EMPLOYER ______________

PATIENT BROUGHT: MRI ______________________ X-RAYS ______________

DR'S NOTES____

____

____

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Robert S. Bell, M.D.
Pierre Le Baud, M.D.

Patient Name ________________________________ **(Please fill out completely)**

Your Gender:

_____Male _____* Female * Are you pregnant, or a possibility that you are pregnant? ____ Yes ____ No

Your Race: (check all that apply)

_____White _____Black or African-American _____Hispanic
_____Native American _____Asian or Pacific Islander _____Other (please specify)

How much schooling have you completed?

_____Less than high school _____Graduated from high school _____Some College
_____Graduated from college _____Postgraduate school or degree _____Other (please specify)

What is your marital status?

_____Married _____Living with significant other _____Divorced/Separated
_____Widowed _____Single (never married)

Do you live with someone who can take care of you? _____Yes _____No

Which statement describes your current employment situation: (check all that apply)

_____Currently working _____On leave of absence _____Homemaker
_____Unemployed _____Retired _____Student
_____Disabled and/or retired because of ill health _____Other (please specify)

Are you on or planning to apply to any of the following programs? (please circle)

	Already on it		**Applied for it**		**Planning to apply**	
Social Security	Yes	No	Yes	No	Yes	No
Disability	Yes	No	Yes	No	Yes	No
Workers Compensation	Yes	No	Yes	No	Yes	No

The following is a list of common health problems. Please circle yes or no in the first column. If you do have the problem, please indicate if you receive some type of treatment or medication for. Indicate if the problem limits any of your activities.

	Do you have the problem?		**Do you receive treatment for it?**		**Does it limit your activities?**	
Heart Disease	Yes	No	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Yes	No
Lung Disease	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No
Ulcer or Stomach Disease	Yes	No	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No	Yes	No
Anemia / other blood disease	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Osteoarthritis	Yes	No	Yes	No	Yes	No
Back pain	Yes	No	Yes	No	Yes	No
Rheumatoid arthritis	Yes	No	Yes	No	Yes	No

Other medical problem:
(please specify) ____

In general, would you say your health is:

_____excellent _____very good _____good _____fair _____poor

Does your health now limit you climbing several flights of stairs?

_____yes, limited a lot _____yes, limited a little _____no, not at all

How much of the time during the past week have you had a lot of energy?

_____All of the time _____most of the time _____some of the time _____none of the time

How much of the time during the past week have you felt downhearted?

_____All of the time _____most of the time _____some of the time _____none of the time

Do you currently smoke cigarettes?

_____Yes _____How much _____Age started smoking
_____No, I quit in the last 6 months _____No, I quit more than 6 months ago
_____I have never smoked

How many alcoholic beverages do you drink per week? _______

If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

_____Very dissatisfied _____Somewhat dissatisfied _____Somewhat satisfied _____Very satisfied
_____Neutral