PERSONAL INFORMATION:

First Name: ______________________ Last Name: ______________________

Address: ______________________

City: ______________________ State: ____________ Zip Code: ____________

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________

Social Security #: ______________________ Birth Date: ______________________

Age: _____ Gender: ___ Male ___ Female Status: ___ Married ___ Divorced _____ Widowed ___ Other

Occupation: ______________________ Employer: ______________________

Work Address: ______________________

City: ______________________ State: ____________ Zip Code: ____________

Emergency Contact: ______________________ Relationship: ______________________

Contact Number: ______________________

How were you referred to us? ______________________

Pharmacy Name: ______________________ Pharmacy Number: ______________________

Primary Care Physician: ______________________ Physician Number: ______________________

INSURANCE: Please provide a copy of your insurance card. If your plan requires a referral, please provide a copy.

Primary Insurance: ______________________

Subscriber Name: ______________________ DOB: ______________________

ID #: ______________________ Group #: ______________________

Secondary Insurance: ______________________

Subscriber Name: ______________________ DOB: ______________________

ID #: ______________________ Group #: ______________________

ATTORNEY REPRESENTATION: (if applicable) ______________________

AUTHORIZATION & ASSIGNMENT:

I authorizethe release of any and all records to Cypress Spine Orthopedics as requested. I authorize payment of any benefits to be paid directly to this facility. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of services rendered, regardless of insurance coverage. I understand if I have an unpaid balance to Cypress Orthopedics and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts. I also understand regardless of scheduled future care, any fees for all services will be immediately due and payable. I understand it is my responsibility to consult with my primary care physician to rule out any underlying medical condition not related to my musculoskeletal condition, and/or symptoms presented.

______________________ ______________________
Signature of Patient or Guardian Date

____
Printed Name of Patient or Guardian

CYPRESS ORTHOPEDICS

ALLERGIES:

Please circle ◯ all that apply:

None	Adhesive	DairyProducts
Iodine	Novocain	SulfaDrugs
Xylocaine	Codeine	Eggs
Environmental (dust,pollen,etc.)	Latex	
Penicillin	Tetracycline	

Please list any additional allergies and your symptoms/reaction:

SOCIAL HISTORY:

Please circle ◯ all that apply:

Alcohol Use	How Often?	Caffeine Use
Alternative Medicine Use	Difficulty Driving	Disability
Financial Difficulty	Recreational Drug Use	Good Support System

Tobacco Use   Chewing Tobacco   Cigar   Pipe   Previous Smoker   Never Smoked

Cigarettes: # Packs Per Day? __________________   How old were you when you started? __________________

Sleep Habits: Less than 6 hours a night   7-9 hours a night   More than 9 hours

SURGICAL HISTORY:

Abdominal Surgery	Amputation	Artificial Joint
Fracture Repair	Laminectomy	Medical Spine Procedure
Pacemaker Implant	Post or Prolonged Bleeding	Removal of Abdominal Adhesions
Anesthetic Complications	Back Surgery	Cervical Fusion
Neck Surgery	Other: ______________________________	

Please list any major accidents, type and year: ______________________________

CYPRESS ORTHOPEDICS

PAST MEDICAL HISTORY:

Please check all that apply:

- ☐ Alcoholism
- ☐ Angina
- ☐ Asthma
- ☐ Ankylosing Spondylosis
- ☐ Back Injury/Pain
- ☐ Blood Transfusion
- ☐ Bowel Problems
- ☐ Cancer: Location
- ☐ C.O.P.D.
- ☐ Coagulopathy
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Joint Sprain: Location
- ☐ Musculoskeletal Problems
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Shoulder Dislocations
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Syncope/Fainting Spells
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Heart Attack (MI)
- ☐ Fibromyalgia
- ☐ CHF
- ☐ SleepApnea
- ☐ Arthritis
- ☐ Hyperlipidemia
- ☐ HIV
- ☐ Other: ______________________________

REVIEW OF SYMPTOMS:

Please check all that apply:

CONSTITUTIONAL:

- ☐ Fever
- ☐ Weight Loss
- ☐ Obesity
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Anxiety
- ☐ Allergies

MUSCULOSKELETAL:

- ☐ Back Pain
- ☐ Headaches
- ☐ Extremity Pain
- ☐ Bone Demineralization
- ☐ Unstable Fracture
- ☐ Spinal Infection
- ☐ Spinal Bone Tumors

NEUROLOGICAL:

- ☐ Sudden Numbness
- ☐ Sudden Headaches
- ☐ Loss of Sensation
- ☐ Confusion
- ☐ Dizziness
- ☐ Slurred Speech
- ☐ Loss of Balance

CARDIOVASCULAR:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Arterial Aneurysm
- ☐ Angina
- ☐ Irregular Heart Beat
- ☐ Bleeding Disorder
- ☐ Heart Attack

RESPIRATORY:

- ☐ Asthma
- ☐ COPD
- ☐ Common Cold
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Cancer
- ☐ Pneumothorax

EYES:

- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Nose Bleed
- ☐ Dry Mouth
- ☐ Change of Taste
- ☐ Bleeding Gums

E,N,M,T:

- ☐ Kidney Infection
- ☐ LossBladderControl
- ☐ Urine Color Change
- ☐ Painful Urination
- ☐ Urine Leakage
- ☐ Urgency
- ☐ Blood in Urine

GASTROINTESTINAL:

- ☐ Diarrhea
- ☐ Blood inStool
- ☐ Abdominal Pain
- ☐ Liver/Gall Condition
- ☐ Nausea/Heartburn
- ☐ Loss Bowel Control
- ☐ Prostate Problems

PATIENT ACKNOWLEDGMENT OF BILLING PRACTICES:

Cypress Orthopedics has many facets to care for patients and their healthcare needs.

A patient may be treating with the professionals and clinicians in one or more of the facets of Cypress Orthopedics. The treating doctors, and clinicians include, but are not limited to:

Dr. Robert S. Bell, MD

Dr. Lynanne Foster, MD

Dr. Bonaventure Ngu, MD

Dr. Stephen Esses, MD

Dr. Nema Uwaydah, MD

Cypress Orthopedics is under the direction of Medical Director, Dr. Robert S. Bell, MD.

Claims for patient care are submitted to insurance companies by Cypress Orthopedics and may list any of our active providers.

By signing this acknowledgment, the patient understands the billing practices of Cypress Orthopedics. lf there are any questions, please contact our office.

____ ____________________________

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS:

Dear Patient,

Please carefully review this notice.

In order to allow you to make a fully-informed decision about your healthcare, the physicians of Cypress Orthopedics (the "Practice") would like to inform you that at some point during the course of your treatment, the providers may refer you to laboratories, diagnostic imaging centers, surgical centers or hospitals to perform diagnostic studies or surgical procedures. The practice wishes to advise you that some or all of the doctors of Cypress Orthopedics have an ownership interest in:

NW Surgery Center
4800 Federal Plaza Dr
Houston, TX 77092

All of the practice's physicians will make referrals to laboratories, diagnostic imaging centers, surgical centers or hospitals, based upon the best interest of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership, interest or compensation arrangement that a physician may have with a particular laboratory or other facility.

You, as a patient, have the right to choose the provider of your healthcare services and the diagnostic facilities where you receive services or treatment.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

_______________________________________ _________________________

Signature of Patient or Guardian Date

AUTHORIZATION FOR TELEPHONE CONTACT

I authorize the staff of Cypress Orthopedics to contact me at my home, cell, or any other alternate phone number that I have listed.

Which phone number do you prefer we contact first? _________ Home _________ Work _________ Cell

______________ (Initial) I authorize Cypress Orthopedicsto leave a voicemail on the above phone in reference to any items that assist the practice in carrying our Treatment, Payments and Healthcare Operations (TPO), such as appointment reminders, insurance items, and any other calls pertaining to my clinical care, including lab results among others.

AUTHORIZATION FOR U.S. MAIL AND EMAIL

Consent for Cypress Orthopedics to mail to my home or email any item is that assist the practice in carrying out TPO, such as appointment reminders, documentation to refer out for services, documentation requested by myself and patient statements. I understand that as with any internet service, there is a risk sending information through email. All records are kept in our Electronic Medical Record.

_________ I acknowledge and consent to receive paper mail _________ I acknowledge and consent to receive email

---

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 agree to receive an electronic copy of the Notice of Privacy Practices (by contacting the office) containing a more complete description of the uses and disclosures of my health information. 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, that you are bound to abide by such restrictions.

By acknowledging below I give my consent for Cypress Orthopedicsto use and disclose my protected health information (PH) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

______________ (Initial) I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Due to the privacy laws mentioned above, we are unable to discuss your PHI (Including appointment information) with any familymember without your expressed consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information.

I authorize Cypress Orthopedics and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain in effect until I notify the office in writing of any changes.

Name of Individual to release Information to: _____________________________________ Relationship: __________________

OR _________ (Initial) I do not wish to designate anyone to have access to my information.

____ ____________________________

Signature of Patient or Guardian Date

____

Printed Name of Patient or Guardian

CYPRESS ORTHOPEDICS

PATIENT HISTORY

Please help us to provide you with the best comprehensive care by completing the following questionnaire.

Date ______________________

First Name: ______________________________ Last Name: ______________________________

CHIEF COMPLAINT:

What is the reason for your visit today? ____

Please mark the severity of your complaint **right now:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **on average:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **at its best:**

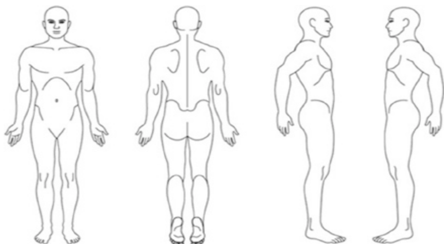
☐ No Symptoms ☐ Discomfort - Does NotAffectActivity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **at its worst:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden



Mark the areas of your complaint on the diagrams to the left. Please include any descriptions or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagram to reflect how the symptoms seem to move.

PAIN DISABILITY INDEX:

Date: ________________________

First Name: ________________________ Last Name: ________________________

For each of the 7 categories listed, please circle the number on the scale that best describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" signifies that all of these types of activities have been totally disrupted or prevented by your pain.

Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

FAMILY/HOME RESPONSIBILITY (such as house cleaning or errands):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

RECREATION (such as sports, exercise, and other similar leisure time activities):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SOCIAL ACTIVITY (such as going to parties, dining out, and other social functions):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

OCCUPATION (all activities related to one's job, including non-paying jobs):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SEXUAL BEHAVIOR:

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SELF-CARE (such as bathing and dressing):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

LIFE-SUPPORT ACTIVITY (eating, sleeping and breathing):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

OVERALL DISABILITY SCORE (OUT OF A POSSIBLE 70): ____________________

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Cypress Orthopedics and the patient who is receiving medical services, or the responsible party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. Your health plan may refuse payment of a claim for some of the following reasons:

- You have not met your full calendar year deductible.
- The type of medical service required is not covered by your plan.
- The health plan was not in effect at the time of service.
- You have other insurance which must be filed first.
- Insurance denied authorization for treatment.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Cypress Orthopedics of the current address and phone number for the patient and the responsible party in the event it changes.
- Pay any required co-pay and/or deductible amount at the time of visit.
- If you are not insured, or if the service being provided is not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your policy. If you health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ____

Responsible Party Name (Please Print): ______________________________________

Patient Signature: ______________________________ Date: ________________

Responsible Party Signature: _________________________Date:________________

STATE–REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION

Texas Law requires the Texas Health Care Information Council to collect information on the race/ ethnic backgrounds of medical clinic patients. Medical practices are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving adequate health care.

If a patient fails or refuses to identify their own race and ethnic backgrounds, facility staff will use its best judgment in making the identification.

QUESTIONS

Mark the line that most accurately identifies the patient's ethnic background.

The Patient Is:

______ Hispanic/Latino

______ Not Hispanic/Latino

______ Patient refuses to answer the question

The Patient's Race Is:

______ American Indian/Eskimo/Aleut

______ Asian or Pacific Islander

______ Black

______ White

______ Other (includes all other responses not listed above. Patients who consider themselves as Multiracial or mixed should choose this category.

______ Patient refuses to answer the question

____ ________________________

Printed Name of Patient Date

____

Signature of Patient or Guardian

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_______________below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____________below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____________listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.**____________listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**______________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.**____________listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

MEDICAL RELEASE FORM

I, ______________________________________ (First and Last Name), do hereby authorize the custodian of records for:

Cypress Orthopedics
11325 Fallbrook Dr.
Houston, Texas 77065
Phone: 281.890.7773
Fax: 281.890.7798

To release and/or obtain a copy of said individual's record(s), which may contain, but are not limited to medical, personal, professional, legal, and financial information. This record may also include, but is not limited to, information received with authorization from other sources in regards to above said individual.

I understand that information contained in this record may be considered personal and confidential.

______________________ ______________________
Printed Name Date of Birth

______________________ ______________________
Signature / Guardian Signature Date

FOR OFFICE USE ONLY
Do Not Fill Out

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

Email: ____