ORTHOPAEDIC ASSOCIATES, L.L.P.

PATIENT HISTORY QUESTIONAIRE
Orthopaedic Associates
Please Print

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Age:**____ **Height:**_____ **Weight:**_____ **Occupation:**_____

Date of Injury or when did you first notice the problem:_____

Type of Injury/Illness:_____

Were you injured on the job? **Yes** **No**

What is your current job description/duties:_____

History of present Illness/injury (how did it happen?):_____

Have you had any previous treatment or tests for this problem? **Yes** **No**

If yes, please list what test or treatment have been performed:_____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

High Blood Pressure	Yes	No	Cancer	Type_____	No
Elevated Cholesterol	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Emphysema/COPD	Yes	No
Asthma	Yes	No	Liver or Kidney Disease	Yes	No
Peptic Ulcers	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Osteoporosis	Yes	No			

DO YOU HAVE A FAMILY HISTORY OF:

High Blood Pressure	Yes	No	Emphysema/COPD	Yes	No
Elevated Cholesterol	Yes	No	Liver or Kidney Disease	Yes	No
Diabetes	Yes	No	Bleeding Disorder	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Peptic Ulcers	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Heart Disease	Yes	No	Cancer	Type_____	No
Osteoporosis	Yes	No			

PLEASE LIST PREVIOUS SURGERIES:

_____ _____

_____ _____

_____ _____

PLEASE LIST MEDICATIONS YOU PRESENTLY ARE ON (Including dosage and strength):

_____ _____

_____ _____

_____ _____

Are you Allergic to any Medications? **Yes** **No**

If yes, please list all allergies and type of reaction:_____

Do you Smoke? **Yes** **No** **If yes, how often?:**_____

Do you drink alcohol? **Yes** **No** **If yes, how often?:**_____

Do you take any illicit drugs? **Yes** **No**

Patient Signature:_____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME:_____ ***TODAY'S DATE:***_____/_____/_____

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM.
WE MUST HAVE "*BOX 1: CONDITION OR DATE OF INJURY*" COMPLETED TO FILE YOUR CLAIM.

1. Please check: ☐ CONDITION ☐ INJURY INJURY DATE:_____/_____/_____(ON OR ABOUT)
   THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary)_____

_____

2. Did the injury occur during work? ☐ YES ☐ NO
3. Were you clocked in? ☐ YES ☐ NO
4. Were you at lunch? ☐ YES ☐ NO

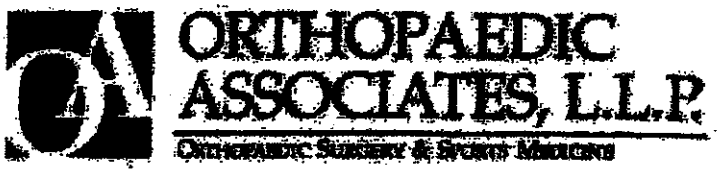
THIRD PARTY LIABILITY

5. Is there a possible third party liability? ☐ YES ☐ NO
   (INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **"non-covered"** service and may make me personally liable for the charges incurred.

SIGNATURE:_____ ***TODAY'S DATE:***_____/_____/_____
(RESPONSIBLE PARTY)



Kaku Barkoh, MD
215 Kingwood Executive Dr, Suite 100
Kingwood, Tx 77339

DISCLOSURE

As a result of Dr. Barkoh's pioneering work and clinical expertise, he is sought after by the medical industry for his knowledge as a consultant. Dr Barkoh acts as a consultant for various companies Amplifly Surgical, Inc. These companies manufacture and sell implantable devices and/or durable medical equipment which may be used in connection with your medical care. He also has ownership interest in Axim Monitoring, PLLC company which performs surgical neurological monitoring.

By my signature below, I hereby acknowledge that I received Dr. Barkoh's biographical information, and notification regarding his ownership interest and consulting work. I also acknowledge that I am free to obtain such medical devices and equipment, hospital services, and/or ambulatory care services from any provider of my choosing, except as my choice be limited by the terms of my health insurance coverage.

Date:_____ Time:_____ AM/PM_____

_____

Signature of Patient or other Legally Responsible Person with Relationship to Patient

_____

ORTHOPAEDIC ASSOCIATES, LLP • FINANCIAL POLICY

WELCOME, and thank you for choosing Orthopaedic Associates, L.L.P. for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Orthopaedic Associates, L.L.P. at the time of service. O.A. will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles or fees for non-covered services are required at the time of service.

HMO/ PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with an O.A. physician, it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

IF YOU DON'T HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call our billing office at 888-330-1737 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

MEDICARE: If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P. will file Medicare and any supplemental insurance claims to your insurance carrier(s).

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature_____Date_____

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ORTHOPAEDIC ASSOCIATES, L.L.P. to release any information acquired in the course of my treatment that may be ~~necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered,~~ I authorize payment to be made directly to ORTHOPAEDIC ASSOCIATES, L.L.P.

Patient Signature_____Date_____

ANESTHESIA AND HOSPITAL BILLS

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-rays. Questions concerning such bills should be directed to the office of the physician who sent the bill.

Patient Signature_____Date_____

USE OF A PHYSICIAN ASSISTANT OR CO-SURGEON

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.

Patient Signature_____Date_____

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature_____Date_____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

GREGORY P. HARVEY, M.D.
VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
DAVID L. LIN, M.D.
AMY E. RIEDEL, D.P.M.
WASYL FEDORIW, M.D.

GINA WRIGHT
ADMINISTRATOR

CONSENT FOR TREATMENT

This facility has on staff a physician in the deliver of medical (Orthopaedic) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the Supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training and experience. The services may include:

A. Obtaining histories and performing physical exams
B. Ordering and/or performing diagnosis and therapeutic procedure
C. Formulating a working diagnosis
D. Developing and implementing a treatment plan
E. Monitoring the effectiveness of therapeutic interventions
F. Assisting at surgery
G. Offering counseling and education
H. Supplying sample medications and writing prescriptions (where allowed by law)
L. Making appropriate referrals

I have read the above, and hereby consent to the services of a physicians assistant for my health care needs.

I understand that at any time I can refuse to see the physicians assistant and request to see a physician.

Name (please print) _____

Signed_____Date _____

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GINA WRIGHT
ADMINISTRATOR

CONSENT FOR RADIOGRAPHS/INJECTION

I,_____hereby authorize Orthopaedic Associates and staff to perform radiographs of my_____.

I,_____hereby authorize Orthopaedic Associates and staff to give an injection in my_____.

Signed_____Date _____

GREGORY P. HARVEY, M.D.
VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
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DAVID L. LIN, M.D.
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WASYL FEDORIW, M.D.

FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a "surgery", but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

_____ _____

Patient/Guarantor Signature Date

Orthopaedic Associates, LLP

Surgical Assistant Fee Policy

Orthopaedic Associates, LLP has been in the business of providing quality orthopaedic care since 1950. It is our goal to always provide the best care possible and our staff works very closely with you before your surgery, acting as the liaison and patient advocate with the hospital and your insurance company. We work very diligently to obtain all of the necessary precertification and approvals and talk with you about your estimated out of pocket expenses prior to your surgery. We believe that you will find your experience with our office staff and healthcare providers an excellent one.

With all of the new changes that are occurring with the healthcare system, we have found recent challenges with regarding reimbursements with respect to the surgical assistant fee that we charge. Because of this recent challenge, we have been forced to change our policy with respect to that surgical fee that is charged. Not all insurance companies reimburse for the services provided by that surgical assistant. As the orthopaedic procedure you are about to undergo is a technically challenging one, a well-trained surgical assistant is necessary to provide the highest quality of care and give you the successful surgical results that we have been able to do for more than half a century. Accordingly, we will now collect the surgical assistant fee for our surgical assistant, Caitlin Gillespie, PA-C prior to the surgery. This fee will be $350 for primary procedures, which include joint replacement, joint reconstructive procedures, advanced hand reconstructive procedures, etc., and $600 for revision type surgery, or any surgery where the conditions require additional medical assistance such as obesity or very complex reconstructions.

Customarily, we will bill your insurance company for the assistant fees in an effort to obtain payment. If your insurance company pays all or part of the surgical assistant fee, we will reimburse you for the fee that you paid or a portion thereof.

Caitlin Gillespie, PA-C is a certified physician assistant. She is very important to the success of each surgery in which she provides assistance. The assistant fees also encompass the postoperative care, which is considered global, just like the surgeon fees. She is vital to the success of your procedure. She is currently in good standing with the American Academy of Physician Assistants, Texas Academy of Physician Assistants, and National Commission on Certification of Physician Assistants.

Naomi Kitchel is available to go over any questions you may have as a result of this correspondence or any other matter affecting your care. Thank you for your understanding in this manner.

Sincerely,
David Lin, MD

By signing below, I state that I have read the above policy and agree to pay the surgical assistant fee as described above and further understand that if my insurance company pays the fee I will be reimbursed.

_____
Patient Signature

_____
Date

Orthopaedic Associates, L.L.P

Contract for Opioid Therapy

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non – negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.

2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.

3. No refills will be made after clinic hours and on weekends or holidays.

4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.

5. I will not share my medications with anyone.

6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).

7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.

8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.

9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.

10. I will use only **1 (one)** pharmacy to fill my medication.

11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.

13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.

14. I understand that physical **dependence** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.

15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.

16. I am aware that the use of opioids has been associated with the following side effects:

    - Sleepiness and drowsiness
    - Nausea
    - Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic reaction
    - Slow breathing/Slow reflexes and reaction times
    - Low testosterone levels in males

17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.

18. Overdose of this medication may cause **death** by stopping my breathing.

19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications.

20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: _____

Patients Signature:_____Date Signed: _____

Pharmacy:_____Phone #: _____

Date: _____

Patient Name: _____ **DOB:** _____

Preferred Language: _____ **Race/Ethnicity:** _____

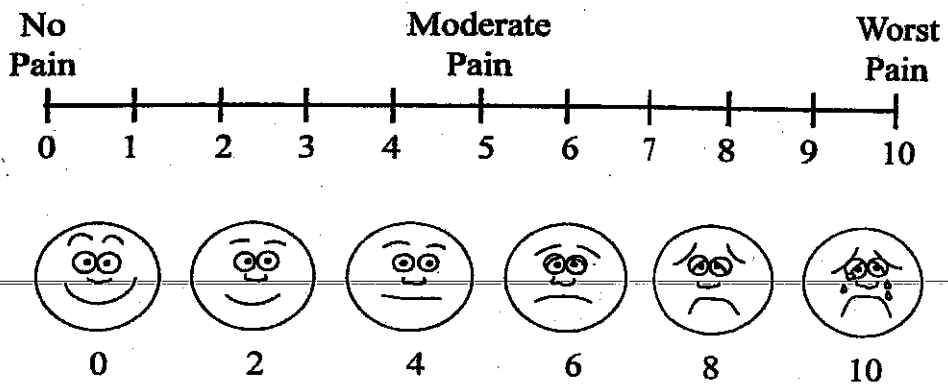
How were you referred to us? _____

Referring Physician Name: _____

Reason for Visit: _____

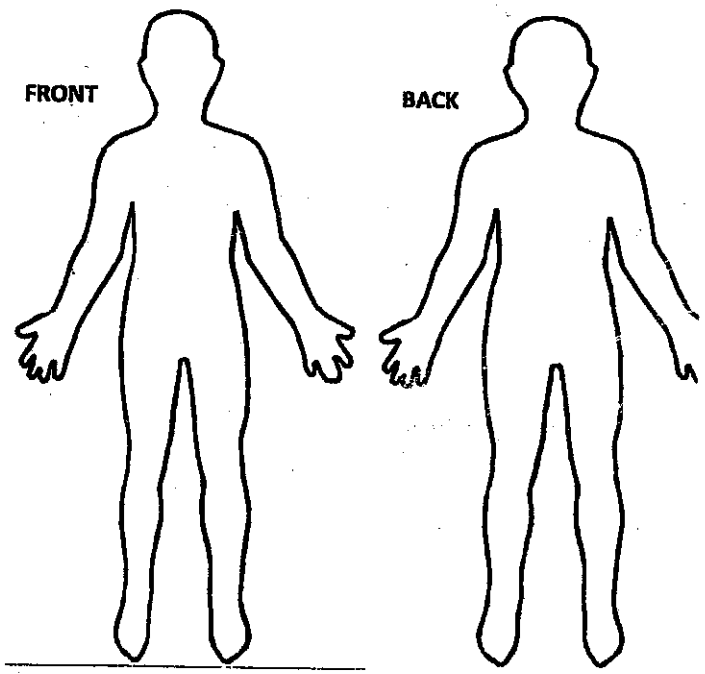
Are you symptoms related to an injury: ___Y ___N Date of injury: _____

What is the degree of pain from the scale of 1-10 that you are currently experiencing? (please Circle)



Please indicate on the chart where you are injured and/or where your site of pain is located → → → → → → → → → →

Nimbness & Tingling	**XXXXXXXXX**
Needles	**0000000000**
Burning	**~~~~~~~~~~**
Stabbing	**//////////**



[redacted]

Aggravating Factors: ___Lifting ___Coughing ___Sneezing ___Standing ___Walking ___Sitting

___Climbing Stairs Other (describe) _____

Describe your pain: ___Constant ___Intermittent ___Unchanged ___Worse ___Better

___Burning ___Sharp-shooting ___Tingling ___Numbness ___Pinprick

___Stabbing ___Deep-Presure ___Tightness ___Spasms

Other(describe)_____

What makes pain worse? _____

What makes pain better? _____

How does the pain limit? _____

Is there any Bowel or Bladder problems? _____

How far are you able to walk without your symptoms causing you to stop and rest? _____

_____

Do you use a: ___Walker ___Cane ___Wheelchair ___Motorized Scooter

Treatment & Eval: ___MRI ___X-Rays ___CT ___EMG ___Bone Scan ___Labs ___Epidurals

Check treatment tried for pain, write how long this treatment was tried if specified.

___Physical Therapy How Long? _____ ___TENS ___Heating Pad ___Ice

___Inversion Table ___Steroid Injection How many injections? _____

___Surgery, What kind? _____ ____Chiropractor, How long? _____

___Exercise, What kind? _____ ____Medication, Which? _____

___Brace, Which? _____ ____Other(describe)_____

Please answer the following questions to the best of your ability.

1. **Have you noticed that you are dropping things or that your hands feel clumsy?** ___Y ___N
2. **Do you feel off-balance or unsteady on your feet?** ___Y ___N
3. **Do you feel weakness in one or both your arms or hands?** ___Y ___N
4. **Do you feel numbness or tingling in one or both of your arms or hands?** ___Y ___N

PERSONAL SAFETY

Do you live alone? ☐ Yes ☐ No If no, who do you live with? Do you use a cane? ☐ Yes ☐ No

Do you have frequent falls? ☐ Yes ☐ No Do you use a wheelchair? ☐ Yes ☐ No

Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No If no, if you would like one to prepare, please notify the staff.

PLEASE CIRCLE ALL THAT APPLY TO YOUR HEALTH CARE PAST OR PRESENT

CONSTITUTIONAL
Fever/Chills
Unexpected Weight Loss
Nausea/Vomiting
Fatigue

EYES
Blurred Vision
Color Blindness
Redness

EAR, NOSE, THROAT AND MOUTH
Deafness
Nose Bleeds
Hoarseness
Ear Ringing
Post Nasal Drip

CARDIO AND VASCULAR
Palpation
Chest Pain
Fainting
Leg Cramps
Heart Murmur

RESPIRATORY
Shortness of breath
Cough
Asthma/Bronchitis
Wheezing
Hurts to breath

GASTROINTESTINAL
Heart Burn
Constipation
Black/Tarry Stools
Diarrhea

MUSCULOSKELETAL
Stiffness
Joint Swelling
Numbness/Tingling
Join Pain
Unsteady Gait

INTEGUMENTARY/BREAST
Skin Rash
Itching
Scarring/keloids
Nail ridging/pitting

PSYCHIATRIC
Hallucinations
Nervousness
Depression
Anxiety

ENDOCRINE
Abnormal Growth
Goiter
Heat/Cold Intolerance
Increase Thirst/Urination

ALLERGIC/IMMUNOLOGIC
Immunosuppressed
Hay Fever
Food/Environmental allergy
Sensitivity to pollen

HEMATOLOGIC/LYMPHATIC
ENLARGEMENT
PAIN