

WELCOME!

Thank you for choosing our practice to serve your medical needs. We are looking forward to seeing you soon.

You may pre-register prior to your visit. Please complete the forms and bring them to your scheduled appointment along with your Driver's License, Medical Insurance card, and Pharmacy Insurance card.

If needed, directions to our office are on our web site (www.srosm.com) or you can use Yahoo's "Maps". Convenient parking is located at our office.

<u>Please bring any of your X-Rays/MRI images and reports</u> with you to the visit. Your doctor will want to see those images. If you do not have the images with you, new ones will need to be taken.

And remember, if you can't make your appointment; call us one business day ahead so that another patient can be scheduled.

If you have questions or need more help, feel free to call our Woodlands office (281-364-1122), Spring office (832-698-0111), or Woodforest office (936-272-0790) at your convenience.

Sincerely,

The Doctors and Staff of Sterling Ridge Orthopaedics and Sports Medicine

SROSM.COM

THE WOODLANDS

6767 LAKE WOODLANDS DRIVE, SUITE F THE WOODLANDS, TX 77382 P: 281.364.1122

F: 281.210.3450

SPRING

20639 KUYKENDAHL ROAD, SUITE 200 SPRING, TX 77379

P: 832.698.0111 F: 832.698.0150 WOODFOREST

750 FISH CREEK THOROUGHFARE, SUITE 100 MONTGOMERY, TX 77316

P: 936.272.0790 F: 936.272.0791



Patient Information and Assignment of Benefits

Patient Last Name _		First Name		Middle Initial				
Street Address					Home Phon	e		
City	State	State Zip Cel		ell Phone	ll Phone Work			
Sex M F	Age Date of Birth		Single	Married	☐ Widowed	☐ Separated	☐ Divorced	
Social Security #		Driver's	License #		Emai	1		
Language	guage				Ethnicity			
How did you learn about our clinic?				Referring	Physician			
Person to contact in e	emergency (Name and Phone	e #)						
	Company Name				Occ	cupation		
EMPLOYER	Address			Phone		Full-time	Part-time	
	City		State	Zip _	Yea	rs Employed		
SPOUSE (PARENT)	NameLast Name			_ Date of Birth	I	SSN		
	Last Name Employer Name							
	AddressPhone		Occupation					
	City		State	Zip		Full-time	Part-time	
PATIENT	Please list patient's primary medical insurance and/or employee health care plan coverage. Insurance Company or Health Care Plan Name							
INSURANCE INFORMATION								
	Policy/Group # Effective Date							
	Name of Insured				_ ID #			
	Insured's relationship to p	oatient:	☐ Self	Spouse	e 🗌 Chil	d 🗆 C	Other	
SECONDARY	· · · · · · · · · · · · · · · · · · ·							
INSURANCE INFORMATION	Insurance Company or Health Care Plan Name							
	Policy/Group #			Effective Date				
	Name of Insured			ID #				
	Insured's relationship to p	oatient:	☐ Self	Spouse	e	Ot	her	



Patient Information and Assignment of Benefits

PHARMACY INSURANCE	Current Pharmacy Phone					
INFORMATION	Please list any pharmacy insurance plans you have					
	Pharmacy Insurance Company					
	RxBIN# RXPCN#					
	ID #Group#					
	Name of Insured Relation to patient					
	Do you prefer Easy Open Lids? Yes No Are Generics Ok? Yes No					
LEGAL INFORMATION	Are your present symptoms of condition related to or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? Yes No Your Initials					
	An accurate medication history is very important to helping us treat you properly and to avoid potentially dangerous drug reactions. Do you grant SROSM permission to access the National Pharmacy Database to retrieve your prescription history? Yes No Your Initials					
	Legal Assignment Of Benefits And Designation Of Authorized Representative					
ASSIGNMENT OF BENEFITS AND ASSIGNMENT OF ERISA RIGHTS	I, the undersigned, have insurance and/or employee health care benefits coverage with the above listed insurance carriers, and for good and valuable consideration I hereby appoint Sterling Ridge Orthopaedics & Sports Medicine (Provider) as my designated Authorized Representative(s). In add I hereby assign and convey directly to the above named healthcare provider(s), all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for the actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby grant the above named provider(s) authority under HIPAA to release all medical information necessary to process my health claims. I hereby authorize any plan administrator, plan fiduciary, and/or insurer and to release to such provider(s) any and all insurance plan documents and a copy of my health insurance policy upon request. If requested, I also authorize my attorney to furnish to provider all third party settlement information upon written request. I also hereby authorize my provider permission to use my signature on all health insurance and/or employee health benefits claim submissions. To the full extent permissible under the law, including but not limited to, ERISA \$502(a)(1)(B) and \$502(a)(3), I hereby assign and convey to the above named provider(s), my benefits in any applicable employee group health plan(s), individual health insurance policy, personal injury protection policy, medical payments policy, underinsured/underinsured motorist policy, third party tort recovery, in order to satisfy any and all medical expenses legally incurred by me for medical services I received from the above named provider(s). Furthermore, to the full extent permissible under the law, I grant to the provider a lien on such medical benefits, settlement, proceed and/or insurance reim					
	The foregoing shall not be construed as an obligation of this medical provider to pursue any legal appeal or legal recovery. Signature of Insured / Guardian Date					



PATIENT MEDICAL HISTORY

		Patient Name: Date:		
Past Medical History Have you ever had any medical problems High Blood Pressure Do you have a pacemaker? Heart Disease Stroke Respiratory Disease (Asthma, COPD) Sleep Apnea Kidney Disease Thyroid Disease AIDS/HIV Hepatitis Rheumatoid Arthritis Have you had surgery?	taking:	Social History: Tobacco (If yes, how much?_Alcohol Do you or have you he chemical dependency For women only: Are you pregnant? Are you breastfeeding Are you using prescrited anyone in your fair Heart Disease Stroke Cancer Bleeding Disorder	☐ Yes ☐ No lad a problem with y? ☐ Yes ☐ No ☐ Yes ☐ No g? ☐ Yes ☐ No ptive birth control?	Yes No

Are you currently being treated for these conditions? Yes / No Explain:_____



Office and Financial Policies

Welcome and thank you for choosing Sterling Ridge Orthopaedics and Sports Medicine for your care. We are committed to providing you with the highest quality medical care in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance will help prevent any misunderstanding or frustration at the time of your visit.

<u>Department Information</u>: Sterling Ridge Orthopaedics & Sports Medicine Pharmacy, Sterling Ridge DME, Chiropractic, and Sterling Ridge Physical/ Occupational Therapy are departments and employees of Sterling Ridge Orthopaedics and Sports Medicine. The information contained in this document applies to each department and medical provider in the Sterling Ridge Orthopaedics and Sports Medicine practice.

No Shows and Late Cancellations: Our office requires 24 hour advance notice if you are unable to keep your scheduled Physician, Chiropractic, or Physical/Occupational Therapy appointment. We value our patients and their needs and when patients do not provide us with advance notice, our office is unable to offer this appointment time to another patient. If you miss a scheduled appointment or fail to cancel your appointment without 24 hour advance notice, your account may be assessed a \$50 fee.

<u>Insurance Requirements</u>: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral <u>in hand</u> at the time of your appointment. If you do not bring your referral with you to your appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

<u>Insurance Claim Filing/Responsibilities</u>: We will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. You are responsible for the timely payment of your account.

<u>Check-In</u>: Please arrive for your appointment at least 15 minutes prior to your appointment time so that all paperwork may be completed before you are scheduled to see one of our medical providers. Please be prepared for co-pays, deductibles, and any past balances or fees for non-covered services prior to seeing your scheduled provider. Also, bring your current insurance card with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the full amount of the charges accrued for the day. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. For your convenience, we accept all major credit cards in addition to cash and check.

<u>Late arrivals</u>: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, we reserve the right to reschedule your appointment so that other patients are not inconvenienced.

Minors: The parent(s) or legal guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Additionally, unaccompanied minors may only obtain treatment from Sterling Ridge Orthopaedics and Sports Medicine medical providers if a parent or legal guardian signs a release to this effect.

<u>Medical Records/Images</u>: Copies of your medical records/images (MRI, X-ray) are available to you upon request at a nominal administrative charge.

Returned Goods (Durable Medical Equipment) Policy: DME is considered a personal use product and once it leaves the office it is considered non-returnable. The two exceptions to this rule are 1) if there is a manufacturer's defect and 2) if the product was not used for surgery due to a physician's request, and should be returned in excellent, unused condition containing all original pieces. If there is a manufacturer defect, the product may be remedied by replacing the product. Your insurance company may not pay for certain services/products based on their determination of "reasonable and necessary" per your insurance company medical policies. If your insurance company determines that a particular service is not "reasonable and necessary" under your insurance company program standards, your insurance company will deny payment for that service. If you receive the service/product and this insurance non-payment occurs, you will be responsible for the amount due.

<u>Consent to Treatment</u>: Knowing that I have a condition requiring health care, I voluntarily authorize and consent to any and all medical treatments as may be deemed advisable by any and all Sterling Ridge Orthopaedics and Sports Medicine healthcare providers. My signature below indicates that I have read, understand, and agree to the office and financial policies outlined in this document. I hereby attest that I have given and have agreed to provide current demographic and insurance information as well as authorizing the release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name:	DOB:
Responsible Person's Signature:	Date: