PATIENT QUESTIONNAIRE

NAME:________________________ DOB:____________ TODAY'S DATE:____________
OCCUPATION: ____________________ AFFECTED SIDE? R or L Who referred you?:____________
What body part are we treating today:______________ DESCRIBE PROBLEM:______________
RACE: □ CAUCASIAN □ AFRICAN AMERICAN □ HISPANIC □ ASIAN □ UNKNOWN □ OTHER
LANGUAGE OF CHOICE:____________ Weight: ______ Height: ______ Do you write with your Left___ or Right___ hand
Gender: Male_________ Female___________ Female patients is there a possibility you may be pregnant: __________
Injury: Yes ____ No_____ If Yes date of Injury: __________ How did injury happen?:______________

PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) [ ] NONE APPLY

___ANEMIA
___ANXIETY
___ASBESTOSIS
___ASTHMA
___BIPOLAR DISORDER
___BLEEDING DISORDER
___BLOOD CLOT
___BRONCHITIS
___CANCER
___CA BRAIN
___CA BREAST
___CA CERVICAL
___CA COLON
___CA KIDNEY
___CA LUNG
___CA OVARIAN
___CA PROSTATE
___CA THYROID
___CHEST PAIN
___CHRONIC BACK PAIN
___COR. ARTERY DISEASE
___CON. HEART FAILURE
___DEPRESSION
___DIABETES
___EMPHYSEMA
___HEART ATTACK
___HEART MURMUR
___HYPERTENSION
___HEART STENT
___HEPATITIS A B C
___IRREGULAR HEARTBEAT
___HIATAL HERNIA
___HIGH CHOLESTEROL
___HIV
___HYPERTHYROIDISM
___HYPOTHYROIDISM
___KIDNEY STONES
___LIVER PROBLEMS
___LUNG PROBLEMS
___LUPUS
___MIGRAINES
___OTHER______________
___NEUROLOGICAL DISORDER
___NUMBNESS/TINGLING
___OSTEOARTHRITIS
___PNEUMONIA
___POOR CIRCULATION
___PULMONARY EMBOLISM
___REFLUX
___RHEUMATOID ARTHRITIS
___SEIZURE
___SLEEP APNEA
___STROKE
___TUBERCULOSIS
___UTI

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) [ ] NONE APPLY

___ABDOMINAL SURGERY
___AMPUTATION
___ANGIOPLASTY
___APPENDECTOMY
___ARTHROSCOPY KNEE
___ARTHROSCOPY SHOULDER
___BRONCHOSCOPY
___CABG
___CAROTID ENDARTERECTOMY
___COLON RESECTION
___FEMORAL BYPASS
___FRACTURE REPAIR
___GALLBLADDER REMOVAL
___GASTRIC BYPASS/BANDING
___HEART SURGERY
___HEMORRHOIDECTOMY
___HIP REPLACEMENT
___HYSTERECTOMY COMPLETE
___HYSTERECTOMY PARTIAL
___INTERVENTIONAL PAIN PROCEDURES
___KNEE REPLACEMENT
___KYPHOPLASTY
___NEPHRECTOMY
___PACEMAKER
___PARATHYROIDECTOMY
___PNEUMONECTOMY
___PROSTATECTOMY
___ROTATOR CUFF REPAIR
___SPINE SURGERY CERVICAL
___SPINE SURGERY THORACIC
___SPINE SURGERY LUMBAR
___TONSILLECTOMY
___T U R P
___VASECTOMY
___VERTEBROPLASTY
___OTHER______________

FAMILY HISTORY (CHECK ANY THAT APPLY) [ ] NONE APPLY

___ANESTHESIA PROBLEMS ___BLEEDING DISORDER ___ASTHMA ___DIABETES
___OSTEOPOROSIS ___ARTHRITIS ___HYPERTENSION (MOM) ___HYPERTENSION (DAD)
___STROKE ___TUBERCULOSIS ___CANCER ___CA BREAST
___CA CERVICAL ___CA COLON/RECTAL ___CA BRAIN ___CA LUNG
___CA OVARIAN ___CA PROSTATE ___CA KIDNEY ___CA THYROID
___OTHER______________

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) [ ] NONE APPLY

___SINGLE ___CHILD ___PHYSICAL WORK ___STUDENT
___MARRIED ___PIPE SMOKING ___SEDENTARY WORK ___REGULAR DUTY
___DIVORCED ___CHEWING TOBACCO ___RETIRED ___LIGHT DUTY
___WIDOWED ___ALCOHOL ___HOMEMAKER ___OUT OF WORK
___CIGARETTE SMOKING (IF YES) HOW LONG: ___ HOW MANY: ___ PACKS PER DAY

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) [ ] NONE

____________ ____________ ____________
____________ ____________ ____________
____________ ____________ ____________

PHARMACY USED: ______________ PH#______________

ALLERGIES TO MEDICINE: (LIST ALL) [ ] NO ALLERGIES

____
____

Patient Signature: ______________________ **Date:** ____________

Patient Registration
Fondren Orthopedic Group

DATE: ______________ NEW PATIENT _____
UPDATE: _____

PLEASE COMPLETE ENTIRE FORM **PATIENT INFORMATION**

NAME: ____
(Last Name) (First Name) (Middle Initial)

ADDRESS: ____
(City) (State) (Zip Code)

DOB: __________ AGE: ______ MALE / FEMALE MARITAL STATUS: ______ SOCIAL SECURITY #: __________

RACE __________ ETHNICITY __________ PRIMARY LANGUAGE: __________

DRIVER'S LICENSE #: __________ EMPLOYER: __________

HOME NUMBER: __________ CELL PHONE __________ WORK PHONE: __________

EMAIL ADDRESS: __________ @ __________

PRESCRIPTIONS ARE NOW COMPLETED ELECTRONICALLY. PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW:

NAME: __________ PHONE: __________ ADDRESS(CROSS STREETS): __________

HOW WERE YOU REFERRED TO OUR OFFICE? CIRCLE ONE: ONLINE ER FRIEND INSURANCE

PHYSICIAN: __________ MAGAZINE: __________
(If by a physician please print physician's full name and phone number)

INSURANCE INFORMATION

***** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM *****

PRIMARY INSURANCE: __________ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? __________ DOB: __________ SS#: __________

EMPLOYER NAME: __________ PHONE: __________ RELATIONSHIP TO PATIENT: __________

SECONDARY INSURANCE: __________ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? __________ DOB: __________ SS#: __________

EMPLOYER NAME: __________ PHONE: __________ RELATIONSHIP TO PATIENT: __________

GUARANTOR INFORMATION (if different Patient)

SPOUSE PARENT GUARDIAN NAME: __________

EMPLOYER: __________ PHONE: __________

BUSINESS ADDRESS: __________ CELL: __________

MEDICAL HISTORY: (Please answer Yes or No)

ON THE JOB INJURY: YES NO IF YES, DATE OF INJURY: __________ DATE LAST WORKED: __________

MOTOR VEHICLE ACCIDENT: YES NO IF YES DATE IF ACCIDENT: __________

IN CASE OF EMERGENCY

*****PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOU RESIDENCE*****

NAME : __________ RELATIONSHIP: __________ PHONE: __________

ADDRESS: __________

ASSISSGNMENT AND RELEASE

This signature will authorize Fondren Orthopedic Group L.L.P. physicians to provide the indicated Medial/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Fondren Orthopedic Group L.L.P. all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medial information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: __________ Date: __________

Signature of Patient (or parent): __________ Date: __________

Fondren Orthopedic Group L.L.P.
Patient Financial Policy

Thank you for allowing Fondren Orthopedic Group L.L.P. ("Fondren", which as used herein includes its wholly owned subsidiaries and affiliates) to participate in your care. We are committed to providing you with affordable high-quality health care.

Insurance

We participate in a vast majority of insurance plans, including Medicare. If you are insured by a plan we do not participate in, payment in full is expected at each visit. If you are insured by a plan that we participate in, but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing about your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-Covered Services

Please be aware that some, and perhaps all, of the services that you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. If you have any concerns about this, please discuss it with your insurance company before you obtain services from Fondren.

Proof of Insurance

All patients must complete our patient information forms before seeing one of our providers. We must obtain a copy of your driver's license and current insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission

We will submit your insurance claims and assist you in any way that we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Insurance Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Payment Methods

We accept the following methods of payment: cash, personal check, money order, Visa, MasterCard, Discover and American Express. For your convenience, you can make payments on our website by visiting www.fondren.com/payment or by calling our automated payment line at 1-855-279-4376.

Non Payment

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise agreed. If a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

Self-Pay Patients

Patients who are identified as self-pay patients are required to make a deposit prior to their visit of between $200 and $800. If you do not use the balance of your deposit, you will be refunded the amount. If there is a balance due at the time of your visit, that amount is due at that time.

Missed Appointments

Our policy is to charge for missed appointments not canceled within 24 hours of your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment. The fee for missed appointments is $50 per occurrence. Insurance plans generally do not pay for missed appointments and this will be your responsibility.

Subpoenas

If a provider or other staff is subpoenaed to testify in any matter, you will be charged for the time spent by the provider or other staff member. A minimum of two (2) hours will be estimated and collected prior to scheduling the requested testimony.

Patient Discharge

Providers may discharge a patient for a variety of reasons. If a patient has been discharged from the practice, he or she will be notified in writing. The provider will only see the patient for 30 days after the notice for critical injuries. The 30-day grace period is to allow the patient to establish care with another provider. Once discharged, a patient will not be able to continue care with any Fondren provider.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Fondren Orthopedic Group L.L.P.
Benefit Assignment and Authorization

Patient Name: ______________________________

I certify that the information that I have given to Fondren Orthopedic Group L.L.P. ("Fondren," which includes its wholly owned subsidiaries and affiliates) is true and correct to the best of my knowledge and that I am responsible for keeping it updated. I promise to pay to Fondren all charges and expenses for services provided to me by Fondren in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Fondren. I will be personally responsible for all charges for services that are not covered by my insurance carrier. I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Fondren and its representatives and affiliates.

I hereby designate, authorize, and convey to Fondren to the full extent permissible under law and under any applicable insurance policy or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including filing medical claims, appeals and grievances, instituting litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right. or cause of action in connection with such insurance policy or benefit plan (including but not limited to the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R.§2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services that I received from Fondren and, to the extent permissible under the law, to claim on my behalf such benefits, claims or reimbursement, and any other applicable remedy, including fines. This constitutes an express and knowing assignment of ERISA breach and fiduciary duty claims and other legal and/or administrative claims. The rights and abilities discussed in this paragraph also apply to any affiliate of Fondren that provides services to the patient. I understand I can revoke this authorization in writing at any time.

Financial Policy Statement

I acknowledge that I was provided access to a copy of the Patient Financial Policy and that I have read (or had the opportunity to read if I choose) and understand the financial policies and procedures of Fondren Orthopedic Group L.L.P. to include payment methods, financial responsibility, insurance policy provisions, collection activities and service fees. I understand that the policies, procedures and authorizations outlined in the Financial Policy may be amended from time to time at the discretion of Fondren. A photocopy of this Assignment and Authorization shall be as effective and valid as the original.

Patient Signature: ______________________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ______________________ **Relationship to Patient:** ______________________

Responsible Party Signature: ______________________ **Date:** ______________________

Fondren Orthopedic Group L.L.P.
Consents and Notices

Patient Name: ______________________________

Consent for Care and Treatment

I hereby agree and consent for Fondren Orthopedic Group L.L.P. and its subsidiaries and affiliates (collectively "Fondren" as used throughout this form) to furnish medical care and treatment to the patient listed above considered necessary and proper in diagnosing or treating her or her physical condition. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the procedures or treatments. I understand that, should I leave the facility without written consent of my attending physician, I hereby relieve the physician and the facility of all responsibility of my action.

Medication Consent

I give permission for Fondren to access my pharmacy benefits data electronically through online services. This consent will enable Fondren to determine the pharmacy benefits and drug copayments for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives that preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to those pharmacies and download a historic list of all medications prescribed for me by any provider.

Physician's Assistant and Certified/Nurse Practitioner Consent

Fondren and its affiliates utilize Physician's Assistants and Nurse Practitioners (collectively known as "Non-Physician Practitioners") to assist in the delivery of orthopedic medical care. I acknowledge a Non-Physician Practitioner is not a physician. Texas licenses Non-Physician Practitioners. Non-Physician Practitioner can, under the supervision of a physician, diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care and assist at surgery. Supervision does not require the constant physical presence of the supervising physician, but rather overseeing and accepting responsibility for the medical services provided. Fondren, its employees, and affiliates, may bill your insurer or plan administrator fiduciary separately to obtain payment for the services of Non-Physician Providers. I acknowledge this information and consent to the services of Non-Physician Practitioners for my health care needs. I understand that, at any given time, I can request to see the physician instead of a Non-Physician Practitioner.

Patient Referral

I understand that, in some cases, my physician or Non-Physician Practitioner may refer me to an out-of-network provider and that I may have more out-of-pocket costs from such out-of-network provider. It is the patient's responsibility to ensure that any provider from whom the patient seeks treatment is in or out-of-network.

Disclosure of Physicians' Ownerships Interests

Our providers are committed to helping facilitate exceptional care at various healthcare facilities and through other health care providers. By maintaining ownership in other facilities and health care providers, our providers are able to have a voice in administrative and operational direction, resulting in a higher overall quality of care. Pursuant to Federal and Texas Law, I have been informed that either Fondren Orthopedic Group L.L.P., or one or more of its affiliates, physicians, or owners, have a financial interest in one or more of the following organizations: Fondren Advanced Care PLLC and South Main Surgical Alliance, PLLC. You may receive separate billing from each entity. We want you to know that you do have the option to use an alternative health care provider should you choose.

Telephone Consumer Protections Act (TCPA) Notice

I agree that Fondren, or any other collection or servicing agency or agencies retained by Fondren (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers that may result in my incurring fees for the call or text message. I am consenting to communication by email as required by 15 U.S.C. §7001and related state regulations and statutes.

I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre- recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address that I provide to the facility or is otherwise associated with my account.

Email and Text Message Communications

I consent and state my preference to have Fondren communicate with me by email or standard SMS (text) messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. If you do not want to be contacted via email or text message, please indicated your preference by checking this box: ☐

Patient Signature: ______________________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ________________________ **Relationship to Patient:** __________________________

Responsible Party Signature: ____________________ **Date:** _________________________

Fondren Orthopedic Group L.L.P.
Release and Acknowledgement

Patient Name: ____________________

Release of Photos/Radiographs/Videos for Website Publication

☐ I give permission to Fondren Orthopedic Group L.L.P. and its wholly owned subsidiaries and affiliates to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied. I understand that no personally-identifying information will be used.

☐ I DO NOT consent to the use of any pictures/videos/radiographs obtained during my treatment.

Acknowledgement of Receipt of Notice of Privacy Practices

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for review on our website and our front desk.

☐ I acknowledge that I was provided access to a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so choose) and understand the Notice.

☐ I refuse to sign this acknowledgement.

Patient Signature: ____________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ____________________ **Relationship to Patient:** ____________________

Responsible Party Signature: ____________________ **Date:** ____________________

Fondren Orthopedic Group L.L.P.
Friends and Family Information Disclosure

Patient Name: ______________________________

☐ I authorize the release of medical information (by telephone, mail or otherwise) by physicians and staff of Fondren Orthopedic Group L.L.P. and its wholly owned subsidiaries and affiliates to:

Name and Relationship	Address/Phone Number
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

☐ I DO NOT authorize the release of medical information to my family members.

Patient Signature: ______________________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ______________________ **Relationship to Patient:** ________________________

Responsible Party Signature: ____________________ **Date:** ______________________

Fondren Orthopedic Group L.L.P.
Workers' Compensation Disclosure

Patient Name: ______________________________

IMPORTANT NOTICE

The following physicians are non-participating physicians in the Texas Workers' Compensation Program. Therefore, they are not listed as part of the ADL (Approved Doctor List) of the TWCC (Texas Workers' Compensation Commission) and are not authorized in any capacity to treat patients for any work-related injury under the TWCC system.

The following listed are Non-ADL Physicians:

Gary T. Brock M.D.	**Richard J. Kearns, M.D.**
Jeffrey A. Kozak M.D.	

The following physicians do not accept Texas Workers' Compensation related patients:

Barry D. Boone, M.D.	**Jeffrey A. Kozak, M.D.**
Holly J. Jones, M.D.	**Gregory W. Stocks, M.D.**

According to Texas Labor Code § 413.042, the patient is responsible for ALL healthcare expenses incurred if he or she violates Texas Labor Code § 408.022 relating to the selection of a doctor and receives medical treatment from a physician NOT chosen from a list of doctors approved by the commission.

Patient Certification: I hereby certify that the information provided by me is truthful, accurate and correct. I fully understand the above-referenced state law as well as any related regulations.

I have read and understand the above statement regarding WORKERS' COMPENSATION BENEFITS coverage.

☐ This is a work-related condition, injury or symptom.

☐ This is NOT a work-related condition, injury or symptom.

I am scheduled to see Doctor: ______________________________

Financial Obligation: I understand if the information that I provide is inaccurate, Fondren Orthopedic Group L.L.P. and its wholly owned subsidiaries and affiliates (collectively, "Fondren") may not be able to collect payment from the insurance company. I also understand and acknowledge that providing false information on the completed forms will result in serious legal consequences for myself.

I hereby affirm that I am responsible to pay Fondren on demand for my medical services if I violated Texas law and knowingly selected a physician not chosen from a list of doctors approved by the Texas Workers' Compensation Commission. Further, I understand that I will be financially liable if my insurance company declares the service to be work-related resulting in a request for refund, if I do not dispute the issue to declare otherwise.

Patient Signature: ______________________ **Date:** ______________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ______________________ **Relationship to Patient:** ______________

Responsible Party Signature: ______________________ **Date:** ______________

Fondren Orthopedic Group L.L.P.
Patient Financial Disclosure Notice

Patient Name: ______________________________

Pursuant to the requirements of section §105.002 of the Texas Occupations Code, this is to inform you that each of the physicians listed below have a financial ownership interest in Texas Orthopedic Hospital, 7401 Main Street, Houston, Texas 77030 (the "Hospital") and may, indirectly, receive compensation for services you receive at the Hospital.

You, as the patient of one of these physicians, have the option of using an alternative health care facility, other than the Hospital, if you so desire.

James B. Bennett, M.D.
David M. Bloome, M.D.
Mark R. Brinker, M.D.
Gary T. Brock, M.D.
Barrett S. Brown, M.D.
Robert L. Burke, M.D.
C. Craig Crouch, M.D.
T. Bradley Edwards, M.D.
Hussein A. Elkousy, M.D.
Tomiko Fukuda, M.D.
Idris S. Gharbaoui, M.D.
Mufaddal M. Gombera, M.D.
Robin N. Goytia, M.D.
Richard J. Kearns, M.D.
Jeffrey A. Kozak, M.D.
David P. Loncarich, M.D.
Randy M. Luo, M.D.
Vasilios Mathews, M.D.
Michael T. McCann, M.D.
Thomas L. Mehlhoff, M.D.
Anay R. Patel, J.D.
Gregory W. Stocks, M.D.
J. Bryan Williamson, M.D.
David W. Wimberley, M.D.

By signing below, you are attesting that you have read and understand the information provided above.

Patient Signature: ______________________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ______________________ **Relationship to Patient:** __________________________

Responsible Party Signature: ____________________ **Date:** ________________________

Fondren Orthopedic Group L.L.P.
Opioid (Narcotic) Prescription Policy

Patient Name: ______________________________

We understand that physical pain is interpreted differently among all of us and we are sensitive to the fact that many of our patients present to us with physically painful conditions. However, it is also our duty as physicians to minimize harm to patients. Narcotic addiction is a national epidemic. Physicians have been placed on the front line of managing this epidemic and are held accountable. In order to protect our patients and maintain our professional standing, Fondren Orthopedic Group and its wholly owned subsidiaries and affilaites have an established policy for prescribing narcotics.

- Narcotics will not be prescribed for chronic pain conditions; however, they can be prescribed for acute conditions at the discretion of the treating physician.
- If you are under the care of a pain management physician, we expect you to disclose this information on your first visit. Failure to do so would violate your contract with your pain management physician.
- Narcotics will be prescribed post-operatively for a maximum of six to eight weeks depending on the type of surgical procedure performed.
- Prescriptions for narcotics will be dispensed in accordance with the Texas Prescription Monitoring Program. They may not be "called in" to your pharmacy.
- Your prescription history will be reviewed prior to the prescribing of any narcotic medication, pursuant to the Texas Prescription Monitoring Program.
- If you are taking narcotics prescribed by a pain management physician, you will need to receive your post-operative pain medicine from that physician.
- Long-term pain medication needs will require a referral to another physician, such as a pain management physician or primary care provider.
- Refills may take up to three days to process, so you must call well in advance. No refills will be authorized after hours or on weekends. NO EXCEPTIONS. On-call physicians are not authorized to refill narcotic pain medication. You may be asked to come to the office to be reevaluated prior to receiving a refill.
- Lost, damaged or stolen prescriptions will NOT be replaced.
- All medications are to be used as prescribed. Adjustments or increases in the amount of medication should not be done without discussion with the prescribing provider.
- Adverse reactions are to be reported to the physician's office immediately.
- Combining narcotic pain medications may have unrecognized or unpredictable interactions with other pain medications.
- Operating heavy equipment or driving is not permitted when using narcotic pain medications.

We have created this policy to ensure the health and safety of our patients. We appreciate your cooperation.

Patient Signature: ______________________________ **Date:** ____________________

If a patient is a minor (under the age of 18) or incapacitated:

Responsible Party Name: ________________________ **Relationship to Patient:** ________________________

Responsible Party Signature: ____________________ **Date:** ________________________

Fondren Orthopedic Group, LLP

- New Policy for missed appointment not cancelled within 24Hr would be a $50.00 fee per occurrence

- Co-Pay & Payments are due at time of services

- There is a $25.00 fee for FMLA, Disability Forms & Medical Records

- There is a $6.50 fee for X-ray & MRI on a disk

- Please inform us with any changes to Insurance, Phone Numbers & Address

- Please inform us if you need school or work note upon checkout