



SHAWN A. HAYDEN, MD, PHD

PATIENT PERSONAL INFORMATION

Date: ___/___/___

Primary Complaint _____ Injury Date ___/___/___

Work-related: Yes No Auto Accident-related: Yes No Slip and Fall: Yes No

Patient's Name:

First MI Last

If Minor Patient, Guarantor's Name and:

First MI Last

Email Address: _____ We may contact you by email? Yes No

Date of Birth: ___/___/___ SS #: ___-___-___ Marital Status: S M W D

Home Address: _____
Street Apt # City State Zip Code

Cell Phone #: ___-___-___ Home Phone #: ___-___-___

Work Phone #: ___-___-___ (Please circle which phone you prefer us to call)

Employer: _____
Name Street City State Zip Code

Primary Care Physician: _____
Name City Phone #

PCP Referral: _____
Name City Phone #

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

| | | | | | |
|--|-------------------------------------|---------------------------------|--|---------------------------------|-------------|
| Person responsible for bill: Name | Birth date: / / | Address (if different): | Home Phone Number: | | |
| Is this person a patient here? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Occupation: | Employer: | Employer address: | Employer Phone Number: | | |
| Is this patient covered by insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Self Pay: <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ | |
| Please indicate primary insurance: | <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Cigna | <input type="checkbox"/> United | <input type="checkbox"/> Aetna | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicaid | | | | |
| Subscriber's Name: | Subscriber's S.S. #: | Birth date: / / | Group Number: | Policy Number: | Co-Payment: |
| Patient's relationship to subscriber: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other: | |
| Name of secondary insurance (if applicable): | Subscriber's Name: | | Group Number: | Policy Number: | |
| Patient's relationship to subscriber: | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | |

Are you currently under Medical Disability? Yes No Have you filed for Medical Disability? Yes No

If yes, what was the effective date and what medical disability do you have? _____

IN CASE OF EMERGENCY

| | | | |
|--|--------------------------|----------------------|--------------------|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home Phone Number: | Work Phone Number: |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. | | | |
| _____ <i>Patient/Guardian signature</i> | | _____ <i>Date</i> | |

ASSIGNMENT OF BENEFITS

I authorize Shawn A. Hayden, M.D., P.A. to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I assign all medical and surgical benefits, to include major medical benefits, from any source, to which I am entitled, to Shawn A. Hayden, M.D., P.A. This assignment will remain in effect until revoked by me in writing, however, I understand and agree that no assignment of benefits may be revoked for outstanding bills. I understand that I am financially responsible for all charges incurred with Shawn A. Hayden, M.D., P.A. A photocopy of this assignment is to be considered valid as the original.

Medical Office
5509 Pleasant Valley Dr.
Suite 700
Plano, TX 75023

Mailing
PO Box 260963
Plano, TX 75026-0963

214-731-3008 Office
972-608-2026 Fax
Info@OntoOrthopedics.com

I have read and understand the above paragraph.

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PATIENT MEDICAL INFORMATION AND HISTORY

Date: ____/____/____

Patient's Name: _____ Age: _____
 First Last

Height: ____' ____" Weight: _____lbs Blood Pressure: ____/____ Heart Rate: _____

Primary Care Physician: _____
 Name Phone Number

When was your last general physical?: _____

Why are you here today? (your primary complaint) _____

When did you first notice this problem? _____

What treatment have you had? Emergency Room Visit Yes No Date _____

X-Rays Yes No Date _____ CTs Yes No Date _____

MRI Yes No Date _____ Treatment by Primary Care Dr. Yes No Date _____

Chiropractic Care Yes No Date Started _____ Date Ended _____

Have you ever had this problem before? _____

If yes, what treatment did you receive? _____

Did the problem resolve after the treatment? _____

Medical History

Check your current or past medical conditions.

| | Date Started | Current or Past Medical Condition | Date Started |
|--|----------------|--|----------------|
| Asthma/Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Infectious Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Free Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |

Other: _____

PATIENT MEDICAL HISTOR cont.

Past Surgical History:

Type of surgery and what year it was performed.

Surgery: _____ Date: _____ Surgery: _____ Date: _____
Surgery: _____ Date: _____ Surgery: _____ Date: _____
Surgery: _____ Date: _____ Surgery: _____ Date: _____

Pharmacy:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ FAX: _____

Medication:

What medicine do you currently take?

Medication: _____ Dosage: _____ How Often: _____
Medication: _____ Dosage: _____ How Often: _____
Medication: _____ Dosage: _____ How Often: _____
Medication: _____ Dosage: _____ How Often: _____
Medication: _____ Dosage: _____ How Often: _____
Medication: _____ Dosage: _____ How Often: _____

ARE YOU ALLERGIC TO ANY MEDICATION? Yes No

If yes, which one(s): _____

ARE YOU ALLERGIC TO LATEX, TAPE, SOAPS? Yes No

If yes, what: _____

Family History:

Is your mother alive? Yes No Age: _____ Illness/Cause of Death: _____

Is your father alive? Yes No Age: _____ Illness/Cause of Death: _____

How many sisters do you have? _____ Any illnesses? If yes, what? _____

How many brothers do you have? _____ Any illnesses? If yes, what? _____

What (if any) illnesses run in your family? _____

PATIENT MEDICAL HISTORY cont.

Past Accident History:

Previous Motor Vehicle Accidents: _____Yes _____No Date: _____

If yes, explain: _____

Previous Slip and Fall accidents: _____Yes _____No Date: _____

If yes, explain: _____

Social History:

Single Married Divorced Separated Widowed

Work Status: Unemployed Retired Employed Occupation: _____

Do you:

Chew tobacco Yes No

Smoke cigars Yes No

Smoke cigarettes Yes No If yes, how many packs per day? _____

Drink alcohol Yes No If yes, how many drinks per day? _____

Take drugs Yes No If yes, what and how much per day? _____

Use herbs Yes No If yes, what and how much per day? _____

Review of Systems:

Have you had any recent change in bowel habits? Yes No

If yes, please describe _____

Have you had any major changes in your weight? Yes No

If yes, please describe _____

(Females only) When is your next menstrual period due? ____/____/____

Are you pregnant? Yes No If yes, what is your due date? ____/____/____

I have completed this medical history information to the best of my ability and recollection.

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

VISUAL ANALOGUE SCALE

NAME _____

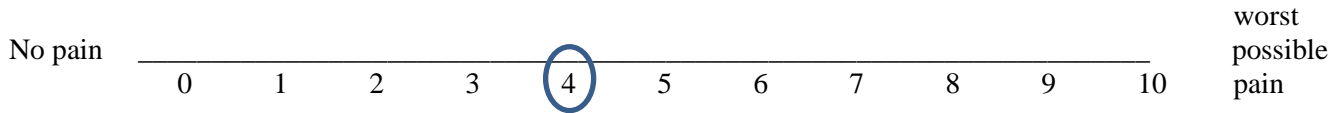
DATE _____

Date of Injury: _____

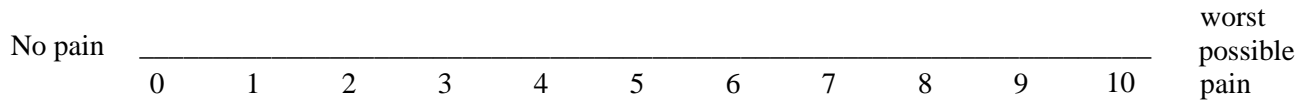
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference.

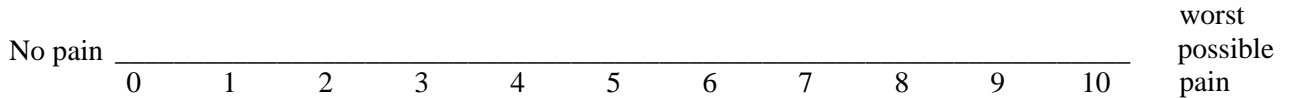
EXAMPLE:



1. ARM or LEG PAIN



2. NECK or BACK PAIN



Circle Pain Area(s) and Label with most appropriate description below

A = ACHE **B = BURNING** **N = NUMBNESS**
P = PINS & NEEDLES **S = STABBING** **O = OTHER**

**PARTIAL ASSIGNMENT OF THE CAUSES OF ACTION,
ASSIGNMENT OF PROCEEDS
CONTRACTUAL LIEN & AUTHORIZATION**

Purpose. The purpose of this Assignment is to improve the ability of the Office to collect my Charges directly from various Payers. Accordingly, I agree to the following and direct all Payers as follows:

Definitions. In this Assignment, the following terms shall have the following meaning: "Office" and "Clinic" shall refer to **Shawn Hayden MD, PA, dba Onto Orthopaedics**; "Payer" shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; "Proceeds" shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers' compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice, regardless of whether such Proceeds relate directly to my Charges or not; "Charges" shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, photocopies, depositions, and testimony), any Collection Costs incurred by the Office, interest and delinquency penalties to the extent permitted by law, and any other charges incurred by me at the Office; "Collection Costs" shall include, without limit, any pre- and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Partial Assignment of the Causes of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign to the Office, insofar as permitted by law, but only to the extent of my Charges, all of my rights, remedies, and benefits relating to any Payer, including without limit my right to receive Proceeds from any Payer now or in the future, and any and all causes of action that I might have against any Payer now or in the future, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further grant a contractual lien to the Office with respect to my Charges. I further intend for this Agreement to create a secured interest under the applicable Uniform Commercial Code and hereby direct the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Consistent with these provisions, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, the Office to the extent of my Charges.

Specific Direction to Any Attorney I Retain, Such as in Accident Cases. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I hereby direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I agree that the purpose of any Proceeds received by the attorney is to pay my Charges.

Other Disclosure Authorization. I hereby direct all Payers to release to the Office any pertinent information regarding any coverage I may have including without limit the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I authorize and direct the Office to release any information regarding my treatment or pertinent to my case(s), including without limit a copy of my Charges and a copy of this Assignment, to all Payers in order to facilitate collection of my Charges.

Miscellaneous Provisions. Except as provided in this paragraph, this Assignment shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Assignment. I agree that each and every provision of this Assignment is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Assignment be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Assignment shall, nevertheless, remain in full force and effect. This Assignment shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Assignment, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Assignment.

I have read, understood, and agree to the terms of this Assignment.

Patient Name (print): _____

Patient Signature: _____ **Date:** ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ **Date:** ____/____/____

FINANCIAL POLICY AND AGREEMENT

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Incorporation of Assignment Terms and Definitions. In this Agreement, "Office" and "Clinic" shall refer to Shawn A. Hayden, MD, PA dba as Onto Orthopaedics. I have reviewed the Office's Assignment form titled in short as "Assignment" or "Assignment / Lien." The terms and definitions contained in the Assignment are incorporated herein by reference.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an accord and satisfaction of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). Without limiting the foregoing, I understand that a Payer may Deny Payment, stating that the Charge is "not a covered benefit" under its policy or exceeds some other limitation. I understand that a Payer may claim, based on internal criteria, that a particular Charge is or was not medically necessary or was not sufficiently documented, and should therefore be denied or downcoded. I further understand that a Payer may require certain Charges to be pre-certified or pre-authorized. I understand that there may be other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office ("Term of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I further agree that should the Office assist me in the verification process, I assume the risk that the Payer and/or the Office may fail to accurately understand or communicate to me the Terms of Non-Coverage. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office liable in any of the foregoing instances.

Collection of Higher of Allowed Amounts When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of an Assignment, to any and all Payers including, without limit, my health benefit plan at the Office sole discretion. I understand that some or all of these Payers may utilize fee schedules to which the Office has agreed or as imposed by law ("allowed fees"). I further understand that the fees allowed or utilized by one Payer may exceed the fees allowed by another Payer. In the event that the fees allowed or utilized by one Payer exceed the fees allowed by another Payer, I hereby authorize and direct the Office insofar as permitted by law to collect its Charges up to, but not in excess of, the higher of the two amounts. In the event that a particular Payer does not utilize any fee schedule at all, I direct the Office to collect up to its full Charges. Finally, I understand that the decision to bill payors is a contract between the office and myself, and will not be changed without the permission of the office.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office

for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. Except as provided in this paragraph, this Agreement shall not be modified or revoked without the expressed, written consent of the Office. I hereby revoke, with the Office's consent, the terms of any previously signed documents, but only to the extent those terms conflict with the terms of this Agreement. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. In any action based upon this Agreement, my treatment, or my Charges, I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non-conveniens as such term is defined by law. I further waive any statute of limitations which may apply in any action based upon this Agreement, my treatment, or my Charges.

Additional Provisions. All office visits, x-rays, deductibles, and office visit co-payments are due and payable at the time of service excepting LOP accounts. Payment will be accepted in the form of cash, check, or major credit card. Outstanding balances that are not paid within 30 days may be subject to a monthly late fee of \$5.00/month or 8% of the total due whichever is greater. Patient requests for Medical Records and/or completion of forms will be charged as allowed by the state and will be completed within 14 business days of written request.

I understand that the insurance policy I choose to elect as my primary insurer is a contract between Shawn A Hayden MD PA and me. I understand that this insurance will remain my primary insurance for the remainder of my care unless a written agreement between Shawn A Hayden MD PA and me elects to change this understanding.

A \$200.00 booking fee is collected for surgery. Following completion of surgery the \$200.00 fee is applied to any outstanding surgical patient fee. If the patient elects to cancel the surgery without a prior 2 week notification, the deposit will be forfeited. Refund time is dependent on insurance adjudication.

The patient understands that a 48 hour notice (during business hours) for all cancellations or scheduling changes is required. Failure of notification will result in a charge of \$75 for all no show appointments. It is understand that exigent circumstances arise that may prevent the patient from providing said notice. These events will be considered on a case by case basis.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print):

Patient Signature:

Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print):

Parent/Guardian Signature:

Date: ____/____/____



SHAWN A. HAYDEN, M.D., Ph.D.

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that ONTO ORTHOPAEDICS provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

ONTO ORTHOPAEDICS RELEASE OF HEALTHCARE INFORMATION

I, _____, authorize Onto Orthopaedics, Shawn A. Hayden, MD,
(Printed Patient/Guardian Name)

and all Onto Orthopaedics employees to release Private Healthcare Information (PHI) to the following person/persons:

| Name | Relationship | Date of Birth |
|------|--------------|---------------|
|------|--------------|---------------|

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|--|--|--|

Medical Office
5509 Pleasant Valley Drive
Suite 700
Plano, Tx, 75023

Mailing
PO Box 260963
Plano, TX 75026-096

**This authorization will remain in effect FOR 1 YEAR FROM DATE SIGNED.
Cancellation must be in writing.**

Patient/Guardian Signature: _____ **Date:** _____