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 no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No	Self Pay ❑ Yes ❑ No	Other ____________________	

Please indicate primary insurance	❑ Blue Cross	❑ Cigna	❑ United	❑ Aetna	
❑ Medicare	❑ Medicaid				

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑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 no.: ( )	Work phone no.: ( )
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.			
Patient/Guardian signature		*Date*	

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.

Midway Medical Center
3108 Midway Road, Suite 104
Plano, TX 75093

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	☐Yes ☐No	___/___/___	Heart Disease	☐Yes ☐No	___/___/___
Blood Transfusion	☐Yes ☐No	___/___/___	High Blood Pressure	☐Yes ☐No	___/___/___
Cancer	☐Yes ☐No	___/___/___	Infectious Disease	☐Yes ☐No	___/___/___
Diabetes	☐Yes ☐No	___/___/___	Lung Disease	☐Yes ☐No	___/___/___
Free Bleeding	☐Yes ☐No	___/___/___	Seizures	☐Yes ☐No	___/___/___
Gout	☐Yes ☐No	___/___/___	Ulcers	☐Yes ☐No	___/___/___

OTHER: ____

PATIENT MEDICAL HISTORY cont.

Past Surgical History:

Type of surgery and what year it was performed.

Surgery: __________________ Year:__________ Surgery: __________________ Year:__________

Surgery: __________________ Year:__________ Surgery: __________________ Year:__________

Surgery: __________________ Year:__________ Surgery: __________________ Year:__________

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 OR SENSITIVE TO LATEX, TAPE, SOAPS? ☐ YES ☐ NO

If yes, what:____

Family History:

Is your Mother alive? ☐Yes ☐No Age: _________ Illnesses/Cause of Death: ___________________

Is your Father alive? ☐Yes ☐No Age: _________ Illnesses/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: ______No _____Yes Date:______________________

If yes, explain____

Previous Slip and Fall accidents: ______No _____Yes 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: _____________

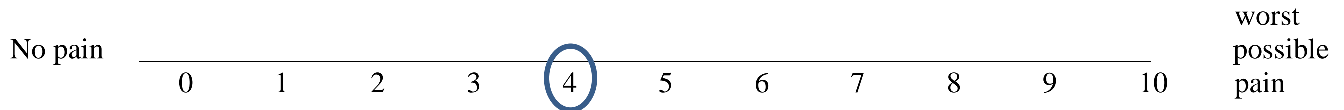
VISUAL ANALOGUE SCALE

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:



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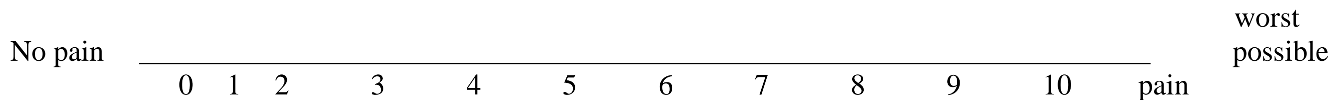
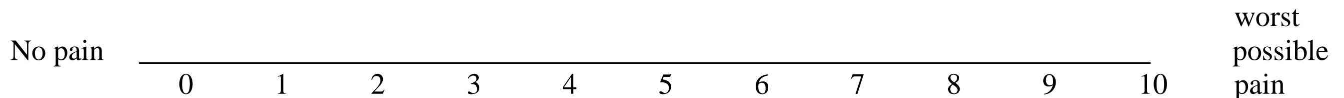
1. ARM or LEG PAIN



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 ORTHPAEDICS 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

____

Name Relationship Date of Birth

____

Name Relationship Date of Birth

____

Name Relationship Date of Birth

Midway Medical Center
3108 Midway Road, Suite 104
Plano, TX 75093

Mailing
PO Box 260963
Plano, TX 75026-0963

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

Patient/Guardian Signature:______________________________________ **Date:** ____________