RICHARD D. JELSMA, MD

Board Certified Orthopedic Surgeon
425 North Highland. Suite 110
Sherman TX 75092
(903) 868-8800 / Fax: (903) 868-4405

Appointment Date: ___________________________

Appointment Time: ___________________________

Dear New Patient,

Thank you for choosing us to serve you in your orthopedic needs. We look forward to meeting you in person.

Please help us in serving you by completing the enclosed forms and bringing them along with your insurance card(s) with you to your appointment. **You must provide a complete list of medical conditions and medications in order to be seen.** If you have had any X-rays, MRIs, CT scans, EMG nerve conduction studies, or any other radiological tests pertaining to your appointment, you will need to bring all **films** and reports with you. Kindly give the radiological facility 24 - 48 hours advance notice that you will need a copy of your films. Failure to provide your medical information and/or radiological studies may require us to reschedule your appointment.

If you have been treated by another physician, please have them fax all pertinent records to our office at (903) 868-4405. It is your responsibility to obtain these records so that you can be properly treated.

It is our responsibility to collect all co-pays and co-insurance at the time of service. Dr. Jelsma requires a minimum of 24 hours notice for cancellations or rescheduled appointments. Thank you for your understanding and cooperation.

Sincerely,

Richard D. Jelsma, MD

Date: ____________

GUARANTOR'S INFORMATION:

Last Name ____________ First ____________ Middle ____________

Address ____________ City ____________ St ______ Zip ______

Home Phone #(___) ____________ Work Phone #(___) ____________ Ext. ______ Cell #(___) ____________

Date of Birth ____ /____ /____ Social Security # ____________ Driver's License # ____________

Marital Status: ____ Married ____ Single ____ Widow(er) ____ Divorced ____ Separated

Full Time Student: ____ Yes ____ No School Name ____________

Employer ____________ Employer's Phone # ____________

Employer's Address ____________ City ____________ St ______ Zip ______

Name of Spouse (if Applicable) ____________ Date of Birth ____________

Spouse's Employer ____________ Spouse's Phone # ____________

Employer's Address ____________ City ____________ St ______ Zip ______

Nearest Relative/Friend (Not Living With You) ____________ Phone # ____________

PATIENT INFORMATION: (If Different From Guarantor's Information)

Last Name ____________ First ____________ Middle ____________

Address ____________ City ____________ St ______ Zip ______

Home Phone #(___) ____________ Work Phone #(___) ____________ Ext. ______ Cell #(___) ____________

Date of Birth ____ /____ /____ Social Security # ____________ Driver's License # ____________

Marital Status: ____ Married ____ Single ____ Widow(er) ____ Divorced ____ Separated

Full Time Student: ____ Yes ____ No School Name ____________

Employer ____________ Employer's Phone # ____________

Employer's Address ____________ City ____________ St ______ Zip ______

Name of Spouse (if Applicable) ____________ Date of Birth ____________

INSURANCE INFORMATION:

Primary Insurance Company Name: ____________ Phone# (___) ____________

Policy Holder's Name ____________ Date of Birth ____________

Patient's Relationship to the Policy Holder? ____ Self ____ Spouse ____ Child ____ Other ____________

Address ____________ City ____________ St ______ Zip ______

Phone # (___) ____________ Cell (___) ____________

Whom May We Thank For Your Referral? ____________

Name of your Primary Care Physician: ____________ Phone# (___) ____________

AUTHORIZATIONS

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered by Richard D. Jelsma, M.D. either in the office or in the hospital. I request my insurance company to make benefits payable directly to Richard D. Jelsma, M.D., P.A. This is a direct assignment of my rights and benefits under this policy. I authorize the release of any medical information necessary to process my insurance claims. If the patient is a minor, I hereby give my consent to Richard D. Jelsma, M.D. to render both emergency and non-emergency healthcare services both in and out of my physical presence. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Patient / Legal Guardian: ____________ Date: ____________

POS® Reorder # 0107817

PATIENT HISTORY FORM

DATE ____________________

NAME ____________________ AGE ________ SEX: Male _____ Female _____

WHO REFERRED YOU TO OUR OFFICE? ____________________

REASON FOR TODAY'S VISIT: ____________________

HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM BEFORE? ________ IF YES, PLEASE GIVE DETAILS: ______

____

DO YOU CONSIDER THIS A WORK RELATED INJURY? YES _______ NO _______

HISTORY OF PRESENT ILLNESS

PLEASE DESCRIBE YOUR INJURY: ____________________

DESCRIBE HOW YOUR INJURY HAPPENED:

____

____

DATE OF YOUR INJURY: ____________________

MEDICAL HISTORY

MEDICAL PROBLEMS YOU HAVE: ____________________

____

____

YOUR CURRENT MEDICATIONS AND DOSES: ____________________

____

____

YOUR PAST SURGERIES AND DATES: ____________________

____

____

LIST ALL ALLERGIES TO MEDICINES ____________________

____

NAME OF YOUR PRIMARY CARE DOCTOR: ____________________ CARDIOLOGIST ____________________

SOCIAL HISTORY

YOUR OCCUPATION: ____________________ MARITAL STATUS: ____________________ HOW MANY CHILDREN: ____________________

YOUR PERSONAL HABITS: **DO YOU?**	**NO**	**YES**	**IF YES, HOW MUCH**
SMOKE	_______	_______	____________________
DRINK ALCOHOL	_______	_______	____________________

HAVE YOU EVER USED INTRAVENOUS STREET DRUGS? NO _______ YES _______

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING:

	NO	YES
HEADACHES	____	____
DIZZINESS	____	____
BLURRED VISION	____	____
BLACKOUT SPELLS	____	____
SHORTNESS OF BREATH	____	____
PRODUCTIVE COUGH	____	____
CHEST PAIN	____	____
RECURRENT NAUSEA/VOMITING	____	____
ABDOMINAL PAIN	____	____
ABNORMAL COLOR OF STOOL OR URINE	____	____
BURNING ON URINATION	____	____
NUMBNESS IN ARMS OR LEGS	____	____

	NO	YES
ASTHMA OR EMPHYSEMA	____	____
CANCER NO____YES____LOCATION ________		
DIABETES	____	____
EPILEPSY	____	____
GASTRITIS	____	____
HEART DISEASE	____	____
HEPATITIS	____	____
HIGH BLOOD PRESSURE	____	____
HIV	____	____
LUNG DISEASE	____	____
STROKE	____	____
THYROID DISEASE	____	____
ULCERS	____	____

(WOMEN ONLY): COULD YOU BE PREGNANT? _____ Yes _____ No

FAMILY HISTORY

PLEASE LIST ANY HEREDITARY ILLNESSES THAT RUN IN YOUR FAMILY:

____

(For office use only) Medical History Reviewed By: ________________________

PHYSICAL EXAM (physician only)

BP________ RESP________ TEMP________ PULSE________ HEIGHT ________ WEIGHT________

HEENT: ________________

NECK: ________________

CHEST: ________________

HEART: ________________

ABDOMEN: ________________

NEUROLOGIC: ________________

EXTREMITY: ____

____

DIAGNOSTIC TESTS: ____

____

ASSESS/PLAN: ____

____

____

POS Reorder # 0107813

Richard D. Jelsma, M.D.

By signing this form and returning it to Dr. Jelsma's office, I acknowledge that I have received a copy of this notice of privacy practices.

This form will also serve as notice that any services provided outside of Dr. Jelsma's immediate office will not be included in my office visit.

Printed Name of Patient

Authorized Signature of Patient or Guardian Date

Has Dr. Jelsma treated any family members of yours in the past as patients?

Yes __ No __ If yes, who? ________________________________

Effective Date: April 14, 2003

RICHARD D. JELSMA, MD,PA
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our pledge regarding medical information: We understand that medical information about you and your hearth is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this office. We need this record to provide you with quality of care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by office personnel or the physidan.

This notice will tell you about the ways in which we may use and disdose medical Information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical Information.

We are required by law to: make sure that medical information that Identifies you is kept private; give you this notice of our legal duties andjyfvacy practices with respect to medical information about you; and follow the terms of the notice that is currently In effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. However, all of the ways we are permitted to use and disclose Information will fall within one of the categories.

For Treatment We may use medical information about you to provide you with medical treatment or services. We may disdose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved In taking care of you at this office. For example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process. Different personnel In the office may also share medical information ?bout you in order to coordinate the different things you may need, such as prescriptions, physical therapy, lab work and'x-rays. We may also disdose medical information about you to people outside the office who may be involved in your medical care after you leave the office, such as family members, home health or others we use to provide services that are part of your care.

For Payment We may use and disdose medical information about you so that the treatment and services you receive at the office may be billed to and payment may be collected from you, an Insurance company or third party. For example, we may need to give your health plan information about the services you receive here or a surgical facility so your health plan will pay us for your services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment

For Health Care Operations. We may use and disdose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to dedde what, if any, additional services the office should offer, what services are not needed, and whether, ortain new beatments are effective. We may also disdose Information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. We may also combine the medical information we have with medical information from other offices to compare how we are doing and see where we can make improvements In the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Treatment Alternatives. We may use and disdose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services. We may use and disdose medical information to tell you about health related benefits or services that may interest you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical Information about you to a friend or a family member who is involved in your medical care. We may also give Information to someone who helps pay for your care. We may also tell your family and friends that you are treating In our office. In addition, we may disdose medical Information about you to an entity assisting in a disaster relief effort so that your family can be notified of your condition.

As Required bv Law. We will disdose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. .We may use and disdose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent that threat.

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Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical Information about foreign military authority.
Workers' Compensation. We may release information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.
Public Health Risks. We may disdose medical information about you for public health activities. These activities generally indude the following: to prevent or control disease, injury or disability; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.
Hearth Oversight Activities. We may disdose medical information to a health oversight agency for activities authorized by law. These oversight activities indude, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with dvfl rights laws.
Lawsuits and Disputes. If vou are involved in a lawsuit or a dispute, we may disdose medical information about you in response to a court or acministrabAre order. We may also disdose medical information to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited drcumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the hospital; and In emergency drcumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
Coroners. Medical Examiners and Funeral Directors. We may release medical Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to any out their duties.
National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disdose medical Information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may release medical information about you to the correctional Institution or law enforcement offidal. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical Information we maintain about you:
Riant to inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this indudes medical and billing records.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Andrea Hartline or Twilla Seagroves. If you request a copy of the Information, we may charge a fee for the costs of copying, mailing, or other supplies assodated with your request We may deny your request to inspect and copy, in certain very limited drcumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the office will review your request and the denial. The person conducting the review will not be the person who denied your request We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the office.

To request an amendment, your request must be made in writing and submitted to Andrea Hartline or Twilla Seagroves. In addition, you must provide a reason that supports your request We may deny your request for an amendment if it is not made in writing or does not indude a reason to support the request In addition If you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the office; is not part of the information which you would be permitted to inspect or copy; is accurate and complete.

Riflht ft itfl AmHirrtiW Of Disclosures. You have the right to request an Accounting of disclosures." This is a list of the dtedosures we made of medical information about you.

To request this list or accounting of disdosures, you must submit your request in writing to Andrea Harttine or Twilla Seagroves. Your request must state a time period, which may not be longer than six years and my not Include dates before April 14,2003. Your request should Indicate In what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs involved and you may choose to withdraw or modify your requests at that time, before any costs are incurred.

Rioht to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who Is bivolved In your care, like a fairtly merrto cr frtend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree with your request **If** we do agree, we will comply with your request unless the information is needed to provide you emergency treatment

To request restrictions, you must make your request fn writing to Andrea Harrjine or Twilla Seagroves. In your request, you must tell us (1) what information you want to limit (2) whether you want to limit our Use, disdosure or both; and (3) to whom you want the limits to apply, for example, disdosures to your spouse.

Rioht to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Andrea Harrjine or Twilla Seagroves. We will not ask you the reason for your request We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Coov of This fJotice. You have the rioht to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this. To obtain a paper copy of this notice please contact Andrea Harrjine, Receptionist

Changes to this Notice We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information that we already have about you as well as any information we receive In the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand comer, the effective date.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Twilla Seagroves. All complaints must be submitted in writing. You will not be penalized for filing a complaint

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disdose medical Information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disdosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.