Medical City
Orthopedics & Sports Medicine Specialists

Michael Muncy, DO
Carmelita Teeter, MD

**Medical Center Alliance**
3025 N Tarrant Pkwy,
Suite 350
Fort Worth, TX 76177

**Las Colinas**
6750 N. MacArthur Blvd,
Suite 270
Irving, TX 75039

**North Richland Hills**
4300 City Point Drive
Suite 102
North Richland Hills, TX 76180

Dear New Patient,

We are pleased that you have selected Medical City Orthopedics & Sports Medicine to provide your Orthopedic care. It is our mission to provide superior care along with excellent customer service. Your health and well being are our number one priority. Below are a few instructions that will help you prepare for your first appointment:

- ✓ Please arrive 30 minutes prior to your appointment.
- ✓ Please complete the enclosed forms prior to your visit and bring them with you.
- ✓ Please bring all medication bottles, or a list of all your current medications (please include dosage amounts and the number of times taken each day).
- ✓ Bring your current insurance card(s) and copayment (if applicable).
- ✓ Bring a CD(s) of your imaging (X-Rays, MRIs, and CT Scans) Unless they were done at LCMC, NHH, Alliance MC, or Tuscan Imaging
- ✓ Please be certain that your primary care physician has authorized your appointment if your insurance plan requires an authorization. Be sure that you have referrals if required by your insurance plan. Please ensure all authorization and/or referral numbers have been transmitted to our office prior to your appointment. If you have questions regarding your insurance and whether your insurance requires an authorization or referral, please contact your insurance company directly.
- ✓ Please allow 1-2 hours for your appointment.

If you have any questions or concerns prior to your appointment, please don't hesitate to contact us at 214-496-9700.

We look forward to meeting you soon.

The Physicians and Staff of Medical City Orthopedics & Sports Medicine.

Appointment confirmation: ____________________________________________

** For **All HMO Plans** it is the **Patient's Responsibility** to obtain a **Current Referral**, If no referral is obtained the patient will be billed in full for all services provided or services postponed until the proper referral is obtained.**

**If you forget to bring your X-Ray/MRI/CT CD or Films, **not just the report**, we may have to reschedule your appointment. **

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Medical City Orthopedics & Sports Medicine

Michael Muncy, D.O.

Carmelita Teeter, M.D.

**Welcome to our Practice!** Our goal is to provide an exceptional healthcare experience. We believe that in the interest of best healthcare practices, it is necessary to establish practice guidelines/policies between our patients and ourselves in order to avoid misunderstandings. **Please read and initial each line**; by initialing and signing you are acknowledging that you understand our guidelines/policies.

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**WAIT TIMES**

______ We know that your time is valuable and that every patient has unique needs which may require more time than planned. We will make every effort to provide you with exceptional care and to minimize your waiting time. There may be times when an emergency arises or a surgery that takes longer than expected which may cause a delay or rescheduling of your appointment. We will make every effort to accommodate for this, and in the event of a delay or emergency, we will do our best to notify you as soon as possible

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**LATE ARRIVAL**

______ We make every effort to stay on schedule; therefore, it is our policy that if you are more than 10 minutes LATE arriving to your scheduled appointment, you may encounter longer wait times. We will make our best effort to see you in a timely fashion but tardiness may result in longer wait times and or the need to reschedule your appointment. If you are going to be late, please call our office.

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**PHYSICIAN REFERRALS**

______ It is YOUR responsibility to obtain referrals from your primary care physician (PCP) and to ensure that we have received them. If the referral is NOT obtained before your visit, the patient will be liable for payment of services rendered.

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**TELEPHONE CALLS AND MEDICAL QUESTIONS**

______ Each provider has a dedicated clinical team to assist in providing your care. Except in emergencies, our physicians and/or clinical staff do not accept calls when they are in clinic with the patients. If you call during those times, the front office staff will gladly take a message. The clinical team will respond to your calls within 24 hours. If your call is after 3pm, the clinical team will return your call the following business day.

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**FORM COMPLETION**

______ There will be a $25 charge per occurrence for the completion of the following forms

- Disability
- FMLA
- ALFAC
- Supplemental Insurance
- Medical Hardships
- Dictated Work Excuse

**Payment is due when forms are presented. Forms will not be processed without payment.**
**Please allow 5 to 7 business days for completion of forms.**

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**PRESCRIPTION REFILL GUIDELINES**

______ Our office requires **48 hour notice for prescription refills. NO EXCEPTIONS!**

- Medications will be refilled between 8 AM and 4 PM Monday-Friday. No refills on weekends or holidays. The “on-call” physician will NOT refill medications.
- The safety of your prescription is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Secure your medications and keep them away from children.
- Our physicians may not refill medication if you are receiving similar medications from another physician.
- Be aware of the effect of other medications you may be taking. Ask your doctor of pharmacist whether you can take them along with pain medication.
- Do not drink alcohol while taking pain medication. Obey warnings regarding the sedation effect of certain medications.
- Follow the prescribed dose of your medication. Do not share medications with other people and do not take other people’s medications.

**Patient/Guardian Signature: ________________________________________ Date: ________________**

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# Patient Registration Form (Please Print)

**PATIENT INFORMATION**

[ ] Dr. [ ] Miss [ ] Mr. [ ] Mrs. [ ] Ms. Patient's Last Name: ______________________ Suffix: _________

Patient's First Name: ________________________ (MI): _______ Goes by/Previous Name: __________________

Address: ____________________________________________ City, State: __________________ Zip: _______

Phone Number: Home: ___________________ Cell: ______________________ Work: ____________________

Primary Care Provider (PCP): ____________________________________ Phone Number: __________________

Referring Provider (if different from PCP): __________________________ Phone Number: __________________

DOB: (MM)______/(DD)______/(YYYY)_________ Sex: (M/F/T)_____________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Legally Separated [ ] Partner

Social Security Number: ________-_________-___________

Employer Name: _______________________________ Phone Number: ______________________

Employment Status: [ ] Full Time [ ] Part Time [ ] Not Employed [ ] Self Employed [ ] Retired [ ] Military

Student Status: [ ] Full Time Student [ ] Part Time Student [ ] Not a Student

Emergency Contact Name: _________________________________________ Guardian [ ] Yes [ ] No

Emergency Contact Phone Number: _____________________________ Relationship to Patient: _______________

Emergency Contact Address: ________________________________City, State: _________________ Zip: ______

**RESPONSIBLE PARTY INFORMAITON**

Responsible Party: [ ] Self [ ] Guarantor (Only fill out if other than self)

Responsible Party Name (Last): _______________________ (First): _____________________ (MI): _________

DOB: (MM)_____/(DD)_____/(YYYY)_______ Sex: (M/F)_____ Social Security Number: _______-______-_______

Address: ____________________________________________ City, State: __________________ Zip: _______

Employer Name: _______________________________ Phone Number: ______________________

**PRIMARY INSURANCE INFORMATION [ ] SEE CARD**

Insurance Company: ___________________________________ Insurance Phone Number: __________________

Name of Insured: __________________________ DOB: _____/______/______ Relationship to Insured: _________

Subscriber ID/Member ID Number: ________________________________ Group ID Number: ________________

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**SECONDARY INSURANCE INFORMATION – IF APPLICABLE [ ] SEE CARD**

Insurance Company: ________________________________________ Insurance Phone Number: ____________________

Name of Insured: _____________________________ DOB: _____/______/______ Relationship to Insured: __________

Subscriber ID/Member ID Number: ___________________________________ Group ID Number: _________________

**ADDITIONAL INFORMATION**

Street Address (if different from mailing address): ___________________________________________________________

City, State: ___________________ Zip: _______

Email Address: ______________________________________________________________________________________

Race: [ ] American/Indian/Alaska Native [ ] Asian [ ] Native Hawaiian/Pacific Islander [ ] Black/African American
[ ] White [ ] Other [ ] Declined to Report

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined to Report

Language: [ ] English [ ] Spanish [ ] French [ ] Other: _______________ [ ] Declined to Report

Do you need a translator for your appointment: [ ] Yes [ ] No, I'll bring my own interpreter

Preferred Pharmacy: ___________________________________________________________________________________

Address/Cross Street: ______________________________________________ Phone Number: ______________________

**I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.**

**Patient (Or Responsible Party) Signature: ___________________________________ Date: _____________________**

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**PATIENT NAME: __________________________________________ DATE OF B IRTH: _________________**

**PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS**

1. ____________**(Patient or Guardian Initials)**

**Financial Agreement.**

- I acknowledge, that as a courtesy, **Medical City Orthopedics & Sports Medicine** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. ___________**(Patient or Guardian Initials)**

**Third Party Collection**. I acknowledge that **Medical City Orthopedics & Sports Medicine** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ___________**(Patient or Guardian Initials)**

**Assignment of Benefits.** I hereby assign to **Medical City Orthopedics & Sports Medicine** any insurance or other third-party benefits available for health care services provided to me. I understand **Medical City Orthopedics & Sports Medicine** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Medical City Orthopedics & Sports Medicine,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. ______________**(Patient or Guardian Initials)**

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Medical City Orthopedics & Sports Medicine** by the Medicare or Medicaid program.

5. ______________**(Patient or Guardian Initials)**

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for **Medical City Orthopedics & Sports Medicine**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Medical City Orthopedics & Sports Medicine** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Medical City Orthopedics & Sports Medicine** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. ______________**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X________________________________________________________________________Date_________________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

| | |
|---|---|
| Spouse | Guarantor |
| Parent | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify)____________________________________ |

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## General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Signature of Patient or Personal Representative** **Date**

_______________________________________ ____________________

**Printed** Name of Patient or Personal Representative **Relationship to Patient**

_______________________________________ ____________________

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**Consent to Treatment of a Minor**

I, ________________________________________________, Parent/Legal Guardian of

_________________________________________, a minor whose date of birth is ____/_____/_______

do hereby authorize Medical City Orthopedics & Sports Medicine to provide treatment and care which is deemed advisable and rendered under the general or special supervision of a licensed physician.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

I hereby indemnify and hold harmless Medical City Orthopedics & Sports Medicine and their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns, from any and all liability for acting in reliance on this authorization.

I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third party payers who may be responsible for part or all of the cost of the services provided.

_________________________________________ __________________________
Signature of Parent or Legal Guardian Date

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# Health History

Patient Name: __________________ Age: ____ [ ] Female [ ] Male Dominant Hand: [ ] Right [ ] Left

What is the main reason for your visit today: [ ] Pain [ ] Numbness [ ] Weakness [ ] Swelling
[ ] Stiffness [ ] Other: _______________

Did you bring x-rays: [ ] Yes [ ] No

What Body Part is involved? Please mark in the table below: ****We will evaluate one body part per visit**

| Shoulder [ ] R [ ] L | Elbow [ ] R [ ] L | Hand [ ] R [ ] L | Pelvis [ ] R [ ] L | Knee [ ] R [ ] L | Foot [ ] R [ ] L |
|---|---|---|---|---|---|
| Arm [ ] R [ ] L | Wrist [ ] R [ ] L | Finger [ ] R [ ] L<br>T 2 3 4 5 - circle | Hip [ ] R [ ] L | Ankle [ ] R [ ] L | Toe [ ] R [ ] L<br>T 2 3 4 5 - circle |

How long ago did your symptoms start? ______Days ______Weeks _______Months ______Years

Have you had a problem like this before? [ ] Yes [ ] No

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

Comments:

[ ] **No Injury** (Onset was: [ ] Gradual [ ] Sudden) ________________________________________
Why do you think it started? ________________________________________

[ ] **Injury** ([ ] Sport [ ] Accident-**Not Auto or Work**) ________________________________________
Date: _______ Where and how did it happen? ________________________________________
What Sport? ________________________ ________________________________________

[ ] **Injury at Work**: Date: _________________ ________________________________________
From a [ ] Lift [ ] Twist [ ] Fall [ ] Bend [ ] Pull [ ] Reach ________________________________________

[ ] **Work Related-No Injury** ________________________________________
Date: __________ How did you job cause this problem?

On a Scale of 0-10 (10 is the worst) how ***severe*** is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? [ ] Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning

The pain is: [ ] Constant [ ] Comes and Goes Does your pain wake you from sleep? [ ] Yes [ ] No

Do you have any of the following? [ ] Swelling [ ] Bruising [ ] Numbness [ ] Tingling [ ] Weakness

Since my problem started, it is: [ ] Getting Better [ ] Getting Worse [ ] Unchanged

What makes your symptoms ***worse***? [ ] Standing [ ] Walking [ ] Lifting [ ] Exercise [ ] Twisting
[ ] Lying in bed [ ] Bending [ ] Squatting [ ] Kneeling [ ] Stairs [ ] Sitting [ ] Reaching Overhead
[ ] Reaching Behind your back

What makes your symptoms ***better***? [ ] Rest [ ] Elevation [ ] Ice [ ] Heat [ ] Other: _______________

What Medications are you currently taking for *this problem*? ___________________________________

Have you had any of these treatments for *this problem*? [ ] Injection [ ] Brace [ ] Physical Therapy
[ ] Cane/Crutches

What Scans/Tests have you had for *this problem*? [ ] X-Rays [ ] MRI [ ] CT Scan [ ] Bone Scan
[ ] Nerve Test (EMG)

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**Past Medical History:**
Have you ever been diagnosed with any of the following conditions? Check all that apply [ ] None

[ ] Asthma [ ] Stroke [ ] Heart Attack (when?________) [ ] High Cholesterol

[ ] Kidney Failure [ ] Heart Failure [ ] Cancer (location?________) [ ] High Blood Pressure

[ ] Ulcers [ ] Hepatitis [ ] Seizures [ ] HIV [ ] Emphasyema/COPD

[ ] Diabetes [ ] Blood Clots(DVT) or PE [ ] Thyroid Problem [ ] Bipolar Disorder

[ ] Liver Disease Notes/Other: ____________________________________________

**Allergies:** Do you have any ***Allergies*** to any medications? [ ] Yes [ ] No If Yes, please list below:

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

**Past Surgical History:** What Operations have you had (for any reason)? [ ] None ____________________
____________________________________________________________________________

**Family History:**
Have any direct relatives had any of the following disorders? If so, which relative? [ ] None
[ ] Heart Disease ____________ [ ]Lung Cancer ___________ [ ] Breast Cancer __________

[ ] Diabetes ___________ [ ] Rheumatoid arthritis________ [ ] Kidney Disease ______ [ ] Other _____

**Social History:**
Do you use tobacco? [ ]Yes [ ]No Packs/day Alcohol Use? [ ]None [ ]Social [ ]Daily [ ] Frequently
Illegal Drug Use? [ ] Yes [ ] No If yes, what type? ________________________________________

**Review of Systems:**
**Current Symptoms:** [ ] None

**CONST:** [ ] Weight Loss [ ] Frequent Fever [ ] Loss of appetite

**SKIN:** [ ] Frequent Rashes [ ] Skin Ulcers [ ] Psoriasis

**EYE:** [ ] Blurred Vision [ ] Double Vision [ ] Vision Loss

**ENT:** [ ] Hearing Loss [ ] Hoarseness [ ] Trouble swallowing

**RESP:** [ ] Chronic cough [ ] Shortness of Breath [ ] Sleep Apnea

**C-VASC:** [ ] Chest Pain [ ] Palpitations

**GI:** [ ] Heartburn [ ] Ulcers [ ] Nausea [ ] Vomiting [ ] Blood in Stool

**HEME:** [ ] Easy Bleeding [ ] Hemophilia

**GU:** [ ] Painful Urination [ ] Blood in Urine [ ] Kidney Problems

**Neuro:** [ ] Headaches [ ] Dizziness [ ] Seizures

**M/S:** [ ] Gout [ ] Osteo/Rheumatoid Arthritis [ ] Back Pain

**PSYCH:** [ ] Depression [ ] Drug/Alcohol Problem [ ] Insomnia

**ENDO:** [ ] Frequent Thirst [ ] Frequent Urination [ ] Always hot or cold

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TODAY'S DATE: _________________

Patient Name: _____________________________________________ DOB: _________________________

Enter your medications below (include over the counter medications, vitamins, supplements, and Aspirin) or attach your medication list.

Pharmacy Name & Location ________________________________________Phone # _____________________

| MEDICATIONS | | | |
|---|---|---|---|
| Name | Dose / Strength | Frequency | Prescribing Physician |
| *Example: Metoprolol* | *40 mg* | *2 tabs in a.m. & 1 tab in p.m.* | *Dr. Jon Smith (Internal Medicine Doctor)* |
| | | | |
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To the best of my knowledge, all the information provided regarding my health, is complete and correct. I understand that it is my responsibility to inform Medical City Orthopedics & Sports Medicine if I have any changes in my health, or health information.

__________________________________________________ ______________________

Signature of Patient (Or Responsible Party) Date