HENRY J. BLUM, M.D.
Orthopaedic Surgery and Joint reconstruction
Board Certified American Board of Orthopaedic Surgery
Fellow American Academy of Orthopaedic Surgeons

ERIC F. BERKMAN, M.D.
Orthopaedic Surgery and Spine Surgery
Board Certified American Board of Orthopaedic Surgery
Fellow American Academy of Orthopaedic Surgeons

CHARLES L. METZGER, M.D.
Orthopaedic Surgery and Hand and Upper Extremity Surgery
Board Certified American Board of Orthopaedic Surgery
Fellow American Academy of Orthopaedic Surgeons
Certificate of Added Qualification in Hand Surgery

_________________________, 200____

Dear _____________________________:

Dr. Eric Berkman has an ownership interest in and is on Active Staff at Foundation Surgical Hospital, River Oaks Surgical Center, and St. Luke's Sugar Land Hospital. He is also on staff at Memorial Hermann Southwest.

Please sign below to acknowledge receipt of this disclosure.

______________________________	______________________
Signature of Patient or Guardian	**Date**

BELLAIRE
FOUNDATION MEDICAL TOWER
5420 WEST LOOP SOUTH, SUITE 4100
BELLAIRE, TEXAS 77401
PHONE: (713) 333-9333
FAX: (713) 333-9343

SUGAR LAND
THE METHODIST HEALTH CENTER
16651 SOUTHWEST FREEWAY, SUITE 230
SUGAR LAND, TEXAS 77479
PHONE: (281) 265-8181
FAX: (281) 265-6514

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for **Greater Houston Orthopedic Specialists** to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **Greater Houston Orthopedic Specialists.** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party:____

FINANCIAL POLICY STATEMENT

I have read and understand the Financial Policy of **Greater Houston Orthopedic Specialists** I agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies paid, including court costs, collection agency fees, and attorney fees.

PATIENT PRIVACY PRACTICES

I have read and understand the Patient Privacy Practices provided to me by **Greater Houston Orthopedic Specialists** I understand that my personal health information will be used in treatment, payment and operations; including those activities which are performed in order to improve the quality of care. I acknowledge my receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

____
Print Patient's Name Here

____ ____________________
Patient/Guardian/Responsible Party **Date**

____ ____________________
Clinic Representative/Witness **Date**

Greater Houston Orthopedic Specialists
5420 W. Loop South Suite 4100 Bellaire, TX 77401

NEW PATIENT INFORMATION RECORD

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
I acknowledge that I have received the Privacy Notice.

____

Patient or Personal Representative Signature **Date**

If Personal Representative's Signature appears above, please describe Personal Representative's relationship to the patient:____

You are ____________are not___________ authorized to leave a message on my home answering machine regarding my PHI.

You are ____________are not___________ authorized to leave a message on my business voice mail regarding my PHI.

You are ____________are not___________ authorized to leave a message on my cell phone voice mail regarding my PHI.

You are ____________are not___________ authorized to speak to____ ____regarding my PHI.

____

Patient or Personal Representative Signature **Date**

If Personal Representative's Signature appears above, please describe Personal Representative's relationship

to the patient:____

Greater Houston Orthopaedic Specialists

Please complete to the best of your ability / Please Print clearly

Patient Name:______________________________ Today's Date:________________________

Age_______________ Are you? Right handed or Left handed

Referring Doctor:______________________ **or** Referring Friend________________________

Other Physicians who are caring for you:

__________________________________ __________________________________

Describe your problem:____

Duration of Symptoms:____________________ or Date of Injury:_______________________

Cause of Injury:____

Describe your pain: constant / burning / stabbing / shooting / sharp / aching / throbbing

What makes your pain worse?____

What makes your pain better?____

Please rate your pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Studies already performed for this problem? Xrays / CAT scan / MRI / Nerve study / Bone Scan

Treatment so far? None / Anti-inflammatory pills / Physical therapy / Injections / Bracing

Will there be any legal action with respect to this problem? Yes / No / Maybe

Are you represented by an attorney? ____

Review of Systems (Are you experiencing any of the following symptoms?)

Fevers / Night Sweats / Loss of appetite / Unintentional weight loss / Change in bowel or bladder habits / Weakness / Frequent falls / Loss of coordination

Your Own Personal Medical History (check all that apply to you)

__Heart attack	__Stroke / TIA	__Hepatitis / HIV
__Angina (chest pain)	__Seizures	__Cancer____________
__Congestive heart failure	__Diabetes	__ Bladder infections
__High Blood Pressure	__Phlebitis (blood clot)	__Kidney stones
__Asthma/Emphysema	__Pulmonary embolus	__Stomach Ulcers

__Other____

List all surgeries you have had:

___________________________ ___________________________

___________________________ ___________________________

List all medications that you currently take:

_________________________ _________________________ ___________________________

_________________________ _________________________ ___________________________

_________________________ _________________________ ___________________________

List allergies to medications:

_________________________ ________________________ ___________________________

Family Medical History (describe conditions that run in your family):

___________________ _____________________ ___________________ _________________

Social History:

Occupation______________________________ If retired, for how long?______________

Employer ____

With whom do you live?____________________ Are you? Single / Married / Widowed

Do you smoke? If so, How many packs/day?______________________

Do you drink alcohol? If so, how much?____________________________

Height: _____ feet______ inches Weight: _____pounds

Do you have any metal in your body? Yes / No Are you claustrophobic? Yes / No

Authorization to Treat

I hereby grant permission to the physicians of Greater Houston Orthopaedic Specialists to perform such medical and surgical procedures as they deem necessary

Signature___________________________ Today's Date________________

Directions to Foundation Medical Tower Office

5420 West Loop South, Suite 4100
(Between Westpark and Fournace)
Bellaire, TX 77401
(713) 333-9333

From 59 South going north:
Exit Chimney Rock, and turn right on Chimney Rock. Turn left on Westpark. Travel Westpark to the feeder road of 610. Turn right onto the 610 feeder road and the Foundation Medical Tower will be between Westpark and Fournace on the right. **

From 59 North going south:
Exit Newcastle, and turn left on Newcastle under 59. Turn right on Westpark. Turn left onto the feeder road of 610 and the Foundation Medical Tower will be between Westpark and Fournace on the right. **

From 610 North (Galleria area) going south:
Exit Richmond/Hidalgo. The road will circle around to Post Oak. Turn Left on Post Oak. Travel on Post Oak Stay to your left and cross Westpark (at this point you are on the 610 feeder road) and the Foundation Medical Tower will be between Westpark and Fournace on the right. **

From 610 South going north:
Exit Westpark and u-turn onto the feeder road going south, and the Foundation Medical Tower will be between Westpark and Fournace on the right. **

*****The Medical Tower is the second Building, please park in the second parking garage***