ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

☐ Carolyn M. Hyde, MD

Name:_____ Appt Date:_____ _With Doctor: ___Carolyn Hyde_____

Date of Birth:_____ ☐ Male ☐ Female Race_____ Ethnicity_____

Height:_____ Weight:_____ Dominant Hand: ☐ Right ☐Left

Who is your primary physician?_____ ☐ MD/DO ☐ PA Clinic Name:_____

WHO REFERRED YOU TO OUR OFFICE? (Please be as specific as possible…we'd like to thank them!)

☐ Doctor _____	☐ Friend _____
☐ Coach/Trainer _____	☐ Hospital/ER _____
☐ Phone Book	☐ Insurance Plan _____
☐ Web Site	☐ Other _____

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

What is the reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other_____

What body part is involved?

(Please choose body part representing primary reason for visit; additional body part assessment may require new appointment)

☐ Right ☐ Left _____ *(write body part)*

How long have you had this problem? _____days _____week(s) _____month(s) _____year(s) *[timing]*

Was there a specific injury that occurred (if applicable): _____ *[context]*

On a scale of 0 to 10, how severe is your pain? None-0 1 2 3 4 5 6 7 8 9 10 – Severe *[severity]*

Quality of Pain: ☐ Sharp ☐ Knots ☐ Burning ☐ Throbbing ☐ Electric Shocks ☐ Tingling ☐ Aching *[quality]*

The Pain is: ☐ Constant ☐ Intermittent (on and off) ☐ Wakes me at night *[duration]*

Do you have: ☐ Swelling ☐Stiffness ☐Numbness ☐Tingling ☐ Weakness ☐Bruises ☐Locking/Catching ☐Popping (audible/feel) ☐Giving Way ☐ Difficulty Walking ☐ Loss of control of bowel/bladder *[assoc symptoms]*

What makes your symptoms worse? ☐ Standing ☐ Walking ☐Running ☐ Exercise ☐ Sitting ☐ Lifting ☐ Twisting/Pivoting ☐ Stairs ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Coughing ☐ Sneezing ☐ Rising from Chair *[mod factors]*

What makes your symptoms better? ☐ Rest ☐ Elevation ☐ Heat ☐ Cold ☐ Brace/Bandage ☐ Exercise ☐ Therapy ☐Medication (which one(s)?_____)

Have you had any other treatment or surgery for this problem? ☐ Injection ☐Brace ☐Therapy Cane/Crutch ☐ Surgery (list below)

Procedure #1: _____Surgeon:_____ City:_____Date:_____

Procedure #2: _____Surgeon:_____ City:_____Date:_____

What tests have you had for this problem? ☐Xrays ☐MRI ☐CT Scan ☐ Bone Scan ☐EMG/NCV Where?_____

Current work status ☐ Regular ☐ Light Duty (How long? _____) ☐ Not working due to this problem (How long? _____)

PAST MEDICAL HISTORY

PRESENT MEDICATIONS: (if additional space needed, please attach list)

Name of Drug	Dose (include strength & number of pills/day)	How long have you taken this medication?	Reason for taking
1.			
2.			
3.			
4.			

Pharmacy of choice: **Please give name, number and location:** _____

DRUG ALLERGIES: ☐ No ☐ Yes To what?_____

Type of reaction: _____

NATURAL OR ALTERNATIVE THERAPIES (chiropractic, magnets, massage, over-the-counter preparations, vitamins, herbal supplements):_____

PAST MEDICAL HISTORY (continued)

MEDICAL CONDITIONS/ILLNESSES: Do you now or have you ever had…..

☐ Heart disease	☐ Rheumatoid Arthritis	☐ Lung Disease	☐ Migraines	☐ History of blood clots
☐ Hypertension	☐ Kidney Disease	☐ Asthma	☐ Epilepsy	☐ Bleeding problems
☐ Stroke(when?)____	☐ Thyroid Disease	☐ COPD	☐ Depression/anxiety	☐ Problem w/ Anesthesia
☐ Anemia	☐ Lupus	☐ Emphysema	☐ Alcoholism	☐ HIV/AIDS
☐ Cancer-(type?)_____	☐ Diabetes (type?)_____	☐ Pneumonia	☐ Colitis	☐ Hepatitis (type?) _____
☐ Leukemia	☐ Goiter	☐ Tuberculosis	☐ Polio	☐ Stomach Ulcers

Other significant illness (please list):_____

SURGERIES/HOSPITALIZATION (Other than previously listed for your current problem)

Description of surgery/hospitalization	Date	Results/Complications

SOCIAL HISTORY

Employment Status: ☐ Self Employed ☐ Homemaker ☐ Disabled ☐ Retired ☐ Student (Full Time or Part Time?)

☐ Employed (Full Time or Part Time?) Occupation?_____ Employer_____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed **How many people live with you?**_____

Children? ☐ No ☐ Yes If yes, indicate number _____

Do you smoke? ☐ Yes ☐ No ☐ Past- How long ago?_____ If yes, packs per day?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ ___ times/week

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No If yes, please list: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what type and how often? _____

What Hobbies or Sports do you participate in? _____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, which relative?

☐ Irregular Heartbeat	☐Heart disease	☐ Hypertension
☐ Ulcers	☐ Kidney disease	☐ Diabetes (type)_____
☐ Difficulty breathing	☐ Anesthesia reaction	☐ Bleeding disorders
☐ Thyroid disease	☐ Lupus	☐ Rheumatoid Arthritis
☐ Cancer (type)_____	☐ Hepatitis	☐ Stroke

Do any direct relatives have the same condition you are being seen for today? ☐ No ☐ Yes _____

REVIEW OF SYSTEMS (Have you had any of the following?) **YEAR**

Constitutional	☐ None	☐ Weight Loss	☐ Loss of appetite			
Gastrointestinal	☐ None	☐ Heartburn, ulcers	☐ Nausea, vomiting	☐ Blood in stool	☐ Jaundice	
Endocrine	☐ None	☐ Heat or Cold Intolerance	☐ Excessive thirst			
Eyes	☐ None	☐ Blurred vision	☐ Double vision	☐ Vision loss	☐ Dryness	
Ears-Nose-Throat	☐ None	☐ Trouble swallowing	☐ Hoarseness	☐ Hearing loss	☐ Nosebleeds	
Cardiovascular	☐ None	☐ Chest pain	☐ Irregular heartbeat	☐ Palpitations		
Respiratory	☐ None	☐ Shortness of breath	☐ Chronic cough	☐ Wheezing		
Genitourinary	☐ None	☐ Painful urination	☐ Blood in urine	☐ Difficult urination		
Skin	☐ None	☐ Frequent rashes	☐ Skin ulcers	☐ Psoriasis	☐ Lumps	
Neurological	☐ None	☐ Headaches	☐ Dizziness	☐ Seizures		
Psychological	☐ None	☐ Depression	☐ Anxiety	☐ Sleep disorder		
Hematologic	☐ None	☐ Easy bleeding	☐ Easy bruising	☐ Swollen glands		
Musculoskeletal	☐ None	Do your other joints have ☐ Morning stiffness lasting over 30 minutes? ☐ Joint pain or swelling? ☐ Back Pain ☐ Gout				

PLEASE SIGN BELOW: The information on this form is accurate to the best of my knowledge.

Signature_____ **Date**_____

*Office Staff Use Only: Reviewed by:*_____ *Date:*_____

Printed Patient Name: _____ **Acct #:** _____ **Ticket #:**_____ **MD**: **check above**

ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

□ Carolyn M. Hyde, MD

ACCIDENT/INJURY DETAILS

1. A. Current problem is the result of (check all that apply) □ Car Accident □ Work Accident
□ Accident □ Other _____
B. Describe how your accident/injury occurred
_____
_____
_____
C. The accident/injury location was: _____
D. Date of accident/injury: _____

2. A. Were you on the job or was it related to work? □ Yes □ No
B. If yes, your employer's name _____ Phone# _____
C. If yes, did you report it to your employer? □ Yes □ No
D. If self employed, do you carry an accident policy? □ Yes □ No

3. Complete this section if there was an auto accident:
A. I was: □ a driver □ a passenger □ a pedestrian
B. My auto insurance company is: _____
Adjustor's name:_____Ins. Co Phone#_____
Claim or Policy #_____
C. This is the information on the other drivers:

Name_____	Name _____
Phone_____	Phone_____
Ins. Co._____	Ins. Co_____
Claim #_____	Claim #_____

4. If you were NOT in an auto accident, complete this section.
A. Did your injury occur on someone else's property? □ Yes □ No
B. If yes, Name and tel # of property owner _____
Adjustor name_____ Phone #_____
Claim #_____

5. A. Have you received any settlement money or insurance money because of your injury? □ Yes □ No
B. If yes, state: Amount Paid $_____ Who Paid _____

6. A. Do you intend to make any claims other than Health insurance? □ Yes □ No
B. Have you hired an attorney because of the accident? □ Yes □ No
C. If yes, Attorney Name _____ Phone #_____
Attorney address _____

7. If none of the above apply, please explain:

_____

The foregoing is true and correct to the best of my knowledge.

Patient's Name_____ Signature_____
(Print Name) Parent or Guardian (for minor)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

All-Star Orthopedics of Austin has offered me a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that All-Star Orthopedics of Austin reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed below will require a specific authorization prior to disclosure of any medical information.

_____ _____

Patient's **Printed** Name Date of Birth

_____ _____ _____

Patient/Legal Representative **Signature** Date Relationship to Patient

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for All-Star Orthopedics of Austin to share my protected health information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I wish to be contacted in the following manner:

- ☐ Home Phone _____
- ☐ Cell Phone _____
- ☐ Work Phone _____

Ok to leave message with detailed information?

- ☐ Yes ☐ No
- ☐ Yes ☐ No
- ☐ Yes ☐ No

ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

Carolyn M. Hyde, MD

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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities or our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research.. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with healthcare, to protect the health and safety of others, or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice on request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psycho-therapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, **All-Star Orthopedics of Austin, 7200 North Mopac Expressway, Suite 370, Austin, TX 78731**. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:
- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that
- the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of your practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with your to preserve your privacy. *For example* – you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to **All-Star Orthopedics of Austin, 7200 North Mopac Expressway, Suite 370, Austin, TX 78731.** You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about your for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information

If you have questions or would like additional information, you may contact our practice manager at **512.346.4933.**

Effective Date 4/1/12

ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

Carolyn M. Hyde, MD

PATIENT FINANCIAL RESPONSIBILITY AND PAYMENT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The medical services you seek imply a financial responsibility on your part. Please understand that obtaining appropriate authorizations for service, payment of your bill and having a clear understanding of our Financial Responsibility and Payment Policy are important to our professional relationship. Please feel free to ask if you have any questions regarding your financial responsibility.

Our receptionist will ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

Patient Responsibility
As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibilities for any referrals, deductibles, co-insurance, or co-payment amounts **and making sure the doctor you are seeing at All Star Orthopedics of Austin are in network with your insurance company prior to any visit**. Not all services are covered in all insurance contracts. Many insurance contracts require you to have a referral from your primary care provider "PCP" to authorize our office to treat you. You are ultimately responsible for obtaining initial referrals and any follow-up authorizations. You must provide our office your referral/referral number prior to your visit. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, American Express, Discover, and Care Credit

What if I Can't Make My Appointment?
Patients who do not show up on time for an appointment, reschedule, or cancel with less than 24 hours' notice may be charged a $25 fee. A $150 fee may be charges for any missed procedures, such a surgery. This charge will not be reimbursed by your insurance.

Are there fees for Medical Records?
Please be aware of the following medical records related fees: Medical Records copies-$15; $5 mailing fee; CD of Images-$5; FMLA/Disability Forms-$15 initial form, $5 per updated form.

What are Returned Check Fees?
Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per returned check.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office/Surgery Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company**. Obtaining PCP referrals/authorizations Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit. Payment of the patient responsibility for surgery services prior to scheduling surgery services.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
Commercial Insurance- High Deductible Health Plan (HDHP)	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company**. Payment of charges due until deductible and out-of-pocket amounts have been met. Since many HDHPs have deductibles $3000/$4000/$5000 etc, the amounts due at the time of service may be much larger, so please bring means of making payment at the time of service.	Call your insurance company to determine how much of the deductible has been met. Provide an estimate of the charges due for services performed. File an insurance claim as a courtesy to you.

If You Have...	You Are Responsible For...	Our Staff Will...
HMO & PPO plans with which we have a contract	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company.** Obtaining PCP referrals/authorizations If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you & File an insurance claim on your behalf.
HMO with which we are not contracted.	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company.** Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company.** Obtaining PCP referrals/authorizations Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services & File an insurance claim on your behalf.
Medicare	**Making sure the doctor you are seeing at All Star Orthopedics of Austin is in network with your insurance company**. If you have Regular Medicare, and have not met your $147 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

- *I have read, understand, and agree to the above Patient Responsibility and Financial Policy.*

- *I understand that referrals, charges not covered by my insurance company, as well as applicable copayments and deductible* ***are my responsibility and are due at the time of service. In addition, quotes for procedures, calculated by ASOA at the time of service, are just estimates and my final bill will depend on actual charges submitted to my insurance company. I understand I am still responsible for any amounts not covered by my insurance.***

- *I understand that All-Star Orthopedics of Austin will take all necessary and appropriate action to collect any money due from me and that I will be responsible for any and all fees associated with these collection efforts.*

- I authorize my insurance benefits be paid directly to ***All-Star Orthopedics of Austin.***

- *I authorize* ***All-Star Orthopedics of Austin*** *to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

_____ _____ _____

Date **Signature** **Printed Name**

ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

Carolyn M. Hyde, MD

Patient Portal Agreement

ALL-STAR ORTHOPEDICS of AUSTIN provides this site in partnership with e-MDs for the exclusive use of its established patients. The patient portal is designed to enhance patient – physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The information on the patient portal is maintained by **ALL-STAR ORTHOPEDICS of AUSTIN** at its current physical facility – 7200 North MoPac Expressway, Austin, TX 78731.

The patient portal does provide the following services:

- Medication re-fill request
- Communication of laboratory results from staff to patient
- Review patient's medical summary, medication list, and visitation dates
- Limited communication regarding on-going treatment.

The patient portal is not intended to provide internet based diagnostic medical services. Also following limitations apply:

- No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and SEES the doctor.
- No emergent communications or services. Any emergent conditions should be seen by Urgent Care, Emergency Department, or 911.
- No request for narcotic pain medication will be accepted.
- Request for re-fill medication not currently prescribed by **ALL-STAR ORTHOPEDICS of AUSTIN**.
- We are offering the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.
- We will make every attempt to return portal messages within one business day. You must call our office at 512-346-4933 if you have an urgent matter to discuss. Please do NOT use the portal for emergencies.
- We do NOT refill controlled substances over the portal.
- If you are not receiving emails from us, please check your JUNK email folder before contacting us.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold **ALL-STAR ORTHOPEDICS of AUSTIN** responsible for any network infractions beyond your or our control.

The patient portal is provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of patient portal persists, we reserve the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

The patient portal is provided in partnership with e-MDs, our EHR software vendor and provider. The data is stored at this office. The data is on a HIPAA compliant VPN with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events will not occur. To the extent that it is possible, **ALL-STAR ORTHOPEDICS of AUSTIN's** system has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information (PHI) is used at our office. All new and established patients have signed a HIPAA agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed the HIPAA agreement form or need to reacquaint yourself with our HIPAA policy, a print or electronic copy in PDF format will be provided to you for your review.

Once you have signed the Patient Portal Consent Agreement and have provided **ALL-STAR ORTHOPEDICS of AUSTIN** with a legitimate email address that is secure, you will be given our system generated unique user identification and password. The site may be accessed by:

- Directly by going to this URL: http://www.gotomyclinic.com/allstarorthopedic

Upon acceptance by our patient portal system, on the email reply, it will contain your unique user id and password along with PDF Patient Users Guide.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from **ALL-STAR ORTHOPEDICS of AUSTIN** should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

_____	_____	_____
Patient Signature	**Print Name**	**Date**

Email address:_____

ALL STAR ORTHOPEDICS of AUSTIN
Sports Medicine & Orthopedic Surgery

Carolyn M. Hyde, MD

Understanding ASOA Fracture Care Charges

Your insurance company requires that we bill our fracture services to you using a coding system known as CPT (Current Procedural Terminology); these codes are found in the "surgery" section of the CPT codebook. Clearly, this does not mean that you had an operation. However, this is the manner in which the CPT book is organized for ease of use by both insurance companies and physicians.

Therefore, the fracture care services rendered in the office today may be shown on your Explanation of Benefits (EOB) form as a surgical procedure. As such, your insurance company may apply a surgical co-insurance responsibility or deductible. Please know that we have correctly performed and documented the services as required by CPT coding guidelines.

The following is ***included*** in this fracture care fee:
* All office visits 90 days after initial care
* Application of fiberglass cast or splint during initial visit
* Removing all casts and splints
* Modification of the initial cast or splint as needed
* Interpretation of all x-rays regarding the fracture, including x-rays taken elsewhere and brought in by you, as well as x-rays taken in our office.

The following items are ***not included*** under the fracture care code and will be billed separately:
* Crutches, slings, removable casts
* Charges for taking x-rays in our office (interpretation of x-rays is covered under the global fee)
* Any fiberglass cast or splint subsequent to the initial one
* Casting/splinting supply materials

We will bill your insurance company directly for the fracture care charges and you will ***only*** be responsible for charges or services not covered by your insurance company. Please do not hesitate to contact our billing department at (512-277-3162) if you have questions regarding this fracture care policy. Thank you for taking a moment to review this information.

Please sign below to indicate acknowledgment and acceptance of ASOA Fracture Care Policy:

Name_____ Date_____

UNDERSTANDING A GLOBAL FEE

When you are charged a "global" fee for surgery, that fee includes routine follow up care for 90 days from the date of surgery (for the surgery site only), which means you will not have to pay your normal co-pay within that 90 days. X-rays, injections (after 7 days post surgery) and supplies are NOT included in the "global fee" and a charge will be made for these items. Services related to complications are NOT included in the global fee (injections, aspirations etc).

If you are seen in the office during your global period and you are seen for another injury, re-injury or another body part, you will be charged your normal co-pay or deductible.

Please sign below to indicate acknowledgment and acceptance of ASOA Global Fee Policy:

Patient signature _____ Date _____