



## New Patient Forms

# Methodist Hospital - Department of Orthopedics

## CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of Methodist Hospital, Dept. of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at Methodist Hospital, Dept. of Orthopedics. I understand that this consent may be revoked in writing, at any time.

\_\_\_\_\_  
PATIENT NAME (Print Name)

\_\_\_\_\_  
PATIENT DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE OF PATIENT or GUARANTOR, if minor

\_\_\_\_\_  
DATE SIGNED

## ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS  
AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

\_\_\_\_\_  
PATIENT NAME (Print Name)

\_\_\_\_\_  
SIGNATURE OF PATIENT or GUARANTOR, if minor

\_\_\_\_\_  
DATE SIGNED



## Medical History Questionnaire

Medical Center Office  
6550 Fannin, Suite 2500  
Houston, Texas 77030

Pearland Office  
2950 Cullen Parkway Ste 103  
Pearland, Texas 77584

Name: \_\_\_\_\_ Age: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

What are you seeing the doctor for today: (Part of the Body)

\_\_\_\_\_

Referring Physician name, address, and phone number: \_\_\_\_\_

\_\_\_\_\_

Please describe problems(s) you are here for today: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had this problem / date of injury?: \_\_\_\_\_

If this is in result of an injury where did it occur?  Home  School  Auto  Other: \_\_\_\_\_

Please describe the type of pain you are having: (Check all that apply)

- Sharp  Aching  Stabbing  Dull  Cramping  Throbbing  
 Burning  Constant  Pain at night  Comes and Goes  Pin and needles

On a scale of 1-10, how severe is the pain?

- No Pain  1  2  3  4  5  6  7  8  9  10

When does the pain occur? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Any previous treatments or surgery for this current problem?  No  Yes

If so, by whom, when, where? \_\_\_\_\_

Unrelated previous surgeries:  None  Yes \_\_\_\_\_

List all current medications:

	Medication	Dosage	Times/Day
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**Kaare Kolstad Medical Questionnaire**

Please list any medication(s) you have had **allergic** or adverse reaction to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check that apply to **YOU**:

- Asthma/Emphysema    Kidney Disease    Seizures    Stomach ulcers
- Liver Problems    Diabetes    Cancer    Alcoholism
- Chest pain on exertion    Heart Attack    Blood Clots    Drug Abuse
- Shortness of breath    Strokes    Hepatitis \_\_\_\_\_ Birth Control
- High Blood Pressure    Irregular Heart    HIV/AIDS    Gum Disease
- Bleeding Disorder    Psychiatric Disorders    High Cholesterol    Gall Bladder Problems
- Cardiovascular Disease    Neurological Disorders    Skin Disorder

Other: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

- Asthma/Emphysema    Kidney Disease    Seizures    Stomach ulcers
- Liver Problems    Diabetes    Cancer    Alcoholism
- Chest pain on exertion    Heart Attack    Blood Clots    Drug Abuse
- Shortness of breath    Strokes    Hepatitis \_\_\_\_\_ Birth Control
- High Blood Pressure    Irregular Heart    HIV/AIDS    Gum Disease
- Bleeding Disorder    Psychiatric Disorders    High Cholesterol    Gall Bladder Problems
- Cardiovascular Disease    Neurological Disorders    Skin Disorder

Other : \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:**

**The amount you drink and smoke can affect how well bones and ligaments heal and how you react to medicines or anesthesia**

**ALCOHOL**

- I DO NOT DRINK     Average beers a week \_\_\_\_\_
- I am a social drinker     Average glasses of wine a week \_\_\_\_\_
- I am a daily drinker     Average liquor drinks a week \_\_\_\_\_

**TOBACCO**

- I do not smoke
- I smoked but stopped
- I chew tobacco
- I smoke \_\_\_ packs per week since \_\_\_\_\_ (year)

I have read and truthfully answered each questions to the best of my knowledge.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



# The Methodist Hospital Physician Organization

## PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

I GIVE PERMISSION for **Dr. Karre Kolstad** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

I DO NOT GIVE PERMISSION for **Dr. Karre Kolstad** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

I GIVE PERMISSION for any **surgery centers or hospitals associated with Dr. Karre Kolstad's practice** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

I DO NOT GIVE PERMISSION for any **surgery centers or hospitals associated with Dr. Kaare Kolstad's practice** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

\* Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

\* Patient is a minor ( \_\_\_ years of age) \*OR is unable to give permission because: \_\_\_\_\_

Signature of Individual Signing on Behalf of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Legal authority to act on the patient's behalf: \_\_\_\_\_

Kaare Kolstad, M.D.  
Patient Guidelines

**OFFICE HOURS**

Office hours are from 8:00 AM –5:00 PM with lunch from 12:00 AM– 1:00 PM Monday through Friday. Calls will be answered by office personal within 48 hours of you call during these hours. The answering service will pick up the phones during lunch hours, which are forwarded to the office following lunch. (Emergency calls will be answered immediately.) Calls outside of these hours will be received by the answering service who will refer emergency calls to the physician on call.

**MEDICATIONS**

All patients requiring controlled medications (narcotics, etc...) will receive their refills at their office visits or by calling in refills to your pharmacy, which in turns calls us. If your request comes in during **NON/OFFICE** hours, i.e., weekends or holidays, these prescriptions will be called in during the next office day. Medications will NOT be called in on weekends or holidays, so please do not wait until you are out of medication to call in---look ahead and call your pharmacy a couple of days prior to running out. If you have a medication that needs to be pre-certified please find out what else is on your formulary and we will call it in for you.

**FORMS**

There is a charge for all forms. These will be filled out within a reasonable time frame, but not during office hours. Fees will be collected in advance.

**PROCEDURE PRE-CERTIFICATION**

Verifying the type and extent of your personal insurance coverage usually requires 2-5 days for commercial insurance. Pre-authorization through workers compensation insurance may involve a process that could take up to two weeks. Procedures must be pre-certified prior to scheduling. We always strive to finish this process as soon as possible. Once pre-certification is obtained, you will be contacted regarding scheduling of your procedure.

If we have to reschedule your surgery more than two times, then there will be a \$30.00 administrative fee for rescheduling.

If you call us for an emergency situation and are worked in for an appointment that day, then please expect a bit of a wait, as there are patients with regularly scheduled appointments, and we will get you in to see the doctor as soon as possible. Just be patient with us. Thanks

I have read the above, had all my questions answered and understand these guidelines.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

Patient Date of Birth: \_\_\_\_\_

## TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices identifies the general ways your protected health information can be used or disclosed. Protected health information is the individually identifiable personal health information found in your medical and billing records. This information is created or received by a health care provider, insurance company, or employer, and relates to your past, present, or future physical or mental health conditions. This information can be transmitted or maintained in any form by TMH Physician Organization and its Physicians.

This Notice describes your legal rights regarding your health information. It also informs you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated in the individual offices of each physician of TMH Physician Organization. If you receive services by your physician or a health care provider at a different location, there may be different health information privacy policies or notices, and there will be different contact information.

For the purpose of this Notice, the terms "TMH Physician Organization and its Physicians," "TMH Physician Organization," "we" and "our" refer to TMH Physician Organization as an organization as well as each individual physician affiliated with the TMH Physician Organization, with respect to health information generated or maintained by TMH Physician Organization's physicians.

### OUR LEGAL DUTIES

We are required, by law, to keep your identifiable health information private; provide you with this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice as long as it is in effect. If we revise this Notice, we will follow the terms of the revised Notice, as long as it is in effect.

### HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following information describes how we are permitted, or required by law, to use and disclose your health information. Not every use or disclosure in a category will be listed.

**Treatment:** We may use or disclose your medical information to a physician or other health care provider in order to provide care and treatment to you. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to those who may be involved in your medical care outside of TMH Physician Organization, such as hospitals, physicians and others who provide you with health care and medical equipment or product suppliers. We may contact you to provide appointment reminders and to provide you with information about health-related benefits and services provided by TMH Physician Organization or by The Methodist Hospital System, or treatment alternatives that may be of interest to you.

**Payment:** We may use or disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity. For example, we may need to provide your health plan with information about surgery you received so your health plan

will pay TMH Physician Organization or reimburse you for the surgery. We also will tell your health plan about a treatment you are going to receive to obtain the health plan's prior approval for this treatment or to determine whether your plan will cover the treatment.

**Health Care Operations:** We may use or disclose health information about you for activities that are needed to operate and carry out the mission of TMH Physician Organization and The Methodist Hospital System. These activities include: review and improvement of utilization and quality of care and services, evaluation of staff and health care professional performance, competence or qualifications; education and training of physicians and other health care providers; business planning, development and management; and general administrative activities.

**Authorization for Other Disclosures:** We will not use or disclose your health information, except as described in this document, unless you authorize us, in writing, to do so. You can revoke an authorization at any time, in writing. If you revoke an authorization, we will no longer use or disclose your health information for the purpose covered by the authorization. However, we are unable to take back any uses or disclosures already made with your authorization.

**Family and Friends:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care, of your location and general condition. We also will disclose health information to a family member, other relative, close personal friend, or any other person you identify, if the information is relevant to that person's involvement with your care or payment for your care. You can prohibit disclosure of this information.

**Fundraising:** We may use health information about you to contact you in an effort to raise money for our organization and its operations. We may disclose this information to The Methodist Hospital Foundation to assist us in our fundraising activities. Only contact information such as your name, address and telephone number, and the dates you received treatment or services by TMH Physician Organization would be released.

**Public Health and Safety:** We may use or disclose health information, as authorized or required by local, state or federal law, for the following purposes deemed to be in the public interest or benefit:

- To report certain diseases and wounds, births and deaths, and suspected cases of abuse, neglect, or domestic violence;
- To help identify, locate, or report criminal suspects, crime victims, suspicious deaths, or criminal conduct on the premises of TMH Physician Organization's physicians;
- To respond to a court order, subpoena, or other judicial process;
- To assist federal disaster relief efforts;
- To enable product recalls, repairs, or replacements;
- To respond to an audit, inspection, or investigation by a health-related government agency;
- To assist in federal intelligence, counterintelligence, and national security issues;
- To facilitate organ and tissue donations;
- To assist coroners, medical examiners, and funeral directors;
- To respond to a request from a jail or prison regarding an inmate's health or medical treatment;
- To respond to a request from your military command authority (if you are a member or veteran of the armed forces);
- To provide information to a workers' compensation program.

**Business Associates:** There are some services provided by TMH Physician Organization and its Physicians through contracts with business associates. When these services are contracted, we will disclose your health information to the business associate so they can perform the job we have asked them to do. However, we require the business associate to protect your information.

**Registration and Scheduling:** The Methodist Hospital System, of which TMH Physician Organization is an entity, Baylor College of Medicine and Texas Children's Hospital, and their participating organizations

have developed a centralized database to improve scheduling and registration operations. These institutions may share this information to reduce the time you spend registering at any of our facilities.

**Research:** We will use or disclose information in preparation for a research study, to recruit research subjects, or for a research study, after approval by an institutional review board (IRB) when federal or state law does not require your written permission. The IRB reviews research proposals and establishes protocols to protect your safety and the privacy of your health information.

**Special Privacy Protections for Alcohol and Drug Abuse Information:** Alcohol and drug abuse information has special privacy protections. We will not disclose any information identifying an individual as being a patient or provide any medical information relating to the patient's substance abuse treatment unless the patient consents in writing; a court order requires disclosure of the information; medical personnel need the information to meet a medical emergency; qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

## **YOUR HEALTH INFORMATION RIGHTS**

Your medical record that is created after your physician has affiliated with TMH Physician Organization is the property of TMH Physician Organization. You have the following rights, with certain exceptions, regarding the health information that is created about you by TMH Physician Organization and its Physicians.

You have the right to a paper copy of this Notice. In addition, a copy of this Notice also may be obtained at our web site, [www.methodisthealth.com](http://www.methodisthealth.com).

**Confidential Communications:** You have the right to request that we communicate health information to you by an alternate means or location other than your home address and telephone number. Your request must be made in writing to TMH Physician Organization's contact person, and must specify how or where you wish to be contacted. We will try to accommodate your request for alternate communications. If you request an alternate means of communication, that request also should be communicated by you to all of your physicians, including your private physician.

**Restrictions:** You have the right to request that we restrict the use or disclosure of your health information for treatment, payment, or health care operations. While we are not required to agree to your request, if we do agree, your request will be complied with, unless the information is needed to provide emergency treatment to you. Your request must be made in writing to our listed contact person.

**Access:** You have the right to review and obtain a copy of your health information, with certain exceptions. Usually, this includes medical and billing records, but does not include psychotherapy notes. Your request to review or obtain a copy of your health information must be in writing to our listed contact person. You will be charged fees for processing, copying, and postage as authorized by Texas State law.

**Amendment:** If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask for an amendment of that information. You have the right to request an amendment for as long as the information is kept by or for us. Your request for an amendment must be made in writing to our listed contact person, and include a reason that supports your request.

**Accounting of Disclosures:** You have the right to request a list of disclosures that we have made of your health information, except for disclosures made for treatment, payment or health care operations, those authorized by you, and certain other disclosures. Your request must be in writing to our listed contact person, and must state a time period for which you want an accounting. The time period may not

be longer than six years, and may not include dates before your physician(s) affiliated with TMH Physician Organization. The first accounting you request within a twelve-month period will be free. A fee will be charged for additional lists within this same time period.

**Revisions of this Notice:** We reserve the right to change this Notice, and the right to make the new provisions effective for all health information we currently maintain, as well as any information we receive in the future. If we make a major change to this Notice, the revised Notice will be posted in the individual offices of Physicians of TMH Physician Organization and on TMH Physician Organization's web site. In addition, a paper copy of the revised Notice will be available upon request.

**To Report a Complaint:** If you believe your health information privacy rights have been violated, you can file a complaint with us or with the Secretary of the United States Department of Health and Human Services. There will not be any penalty or retaliation against you for making a complaint to us or to the Department of Health and Human Services.

**Contact Information:** If you have any questions or need information regarding our legal duties and privacy practices, or how to exercise any of your health information rights listed in this Notice, please contact:

**Business Practices Officer  
TMH Physician Organization  
6565 Fannin  
Houston, Texas  
713.383.5125**



# The Methodist Hospital Physician Organization

## TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS

### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call TMH Physician Organization's Business Practices Officer at 713.383.5125.

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Patient Name: \_\_\_\_\_

Signature of Patient or  
Patient's Qualified Personal Representative: \_\_\_\_\_ Date  
\_\_\_\_\_

Printed Name of Qualified Personal Representative:  
\_\_\_\_\_

Legal Authority to Act on Behalf of the Patient:  
\_\_\_\_\_

**Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).**

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**For Staff Use Only**

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Date Acknowledgment noted in HIS/patient management system: \_\_\_\_\_

Comments if Notice not provided or Acknowledgment not obtained: \_\_\_\_\_  
\_\_\_\_\_

Processed by: \_\_\_\_\_

# The Methodist Hospital Physician Organization

# The Department of Orthopedics Kaare Kolstad Jr. MD

## OFFICE NUMBERS AND LOCATIONS

Main number: 713-441-3860

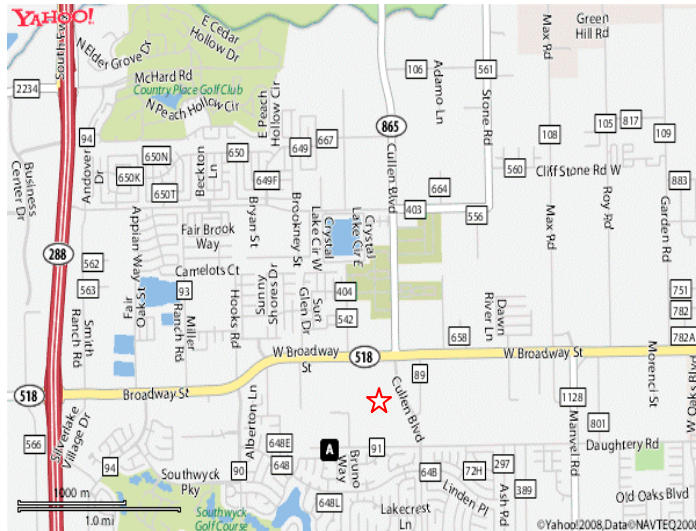
Appointment desk: 713-441-9000

Fax number: 713-790-2202

### Pearland Office

2950 Cullen Parkway, Suite 101

Pearland, Texas 77584



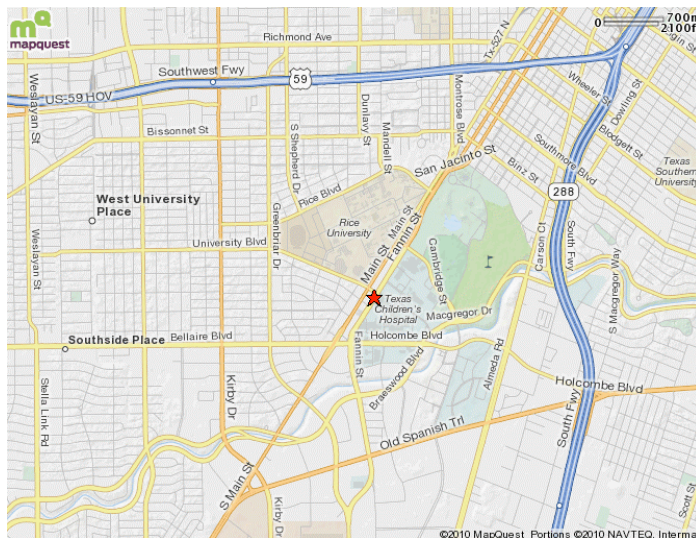
**From 288 North** take 288 to Broadway/518 (Broadway and 518 are the same street) Take a left on 518. Make a right on Cullen we will be on your right side about .5 miles after the Walgreens.

**From Beltway 8** exit Cullen Road go all the way down Cullen, pass 518, we will be on the right hand side about .5 miles after the Walgreens.

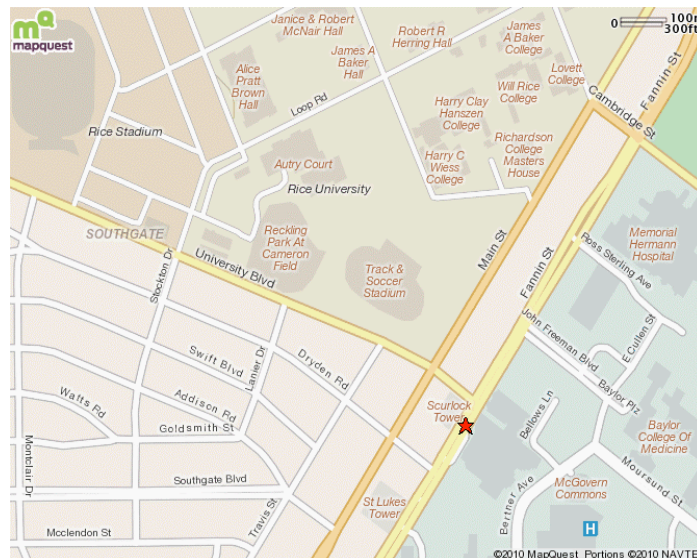
### Medical Center

6550 Fannin Suite 2600 (Smith Tower 26<sup>th</sup> Floor)

Houston, Texas 77030



**From 610 South** Exit Fannin. Take right on Fannin. Go all the way down till you get to University. Make a left on University; on Main you make a right, after you turn right you take a right into Smith Tower Parking Garage.



# We are opening a new office in Pearland as of April 1, 2008.



The Methodist Hospital  
Physician Organization

**2950 Cullen Parkway #101**  
**Pearland, Texas 77584**  
**(713) 441-3860**

