Dear Patient,

Thank you for choosing Dr. Jesse DeLee for your care. The staff and Dr. DeLee would like to ensure your experience is a pleasant one.

In order to better serve you, we ask that you arrive 30 minutes before your scheduled time and bring the following with you to your appointment:

- Current health insurance card
- Current driver's license or a state issued identification card
- Completed new patient information packet
- List of Medications you are currently taking
- If you had an MRI done, please bring a copy of the CD or a copy of the report with you; If you do not, the appointment will have to be rescheduled.

Patients with HMO's or PPO's, please contact your Primary Care Physician (PCP) prior to your visit to obtain a referral. Please note that most PCP's are requesting that patients call for the referral at least two weeks in advance. They may fax the referral to our office at (210) 587-8127.

Payment will continue to be collected for services your insurance considers non-covered, copays or any self pay services at time of appointment. For your convenience, we accept personal checks, Visa, Master Card, American Express and Diners Club.

If you have any questions regarding your appointment, please feel free to contact our office at (210) 351-6500,

Sincerely,

The Office of Dr. Jesse C. Delee

Today's Date: ______________________ New. ______________________ Update: ______________________

PATIENT INFORMATION

Name: (last) ______________________ (First) ______________________ (Middle) ______________________

Social Security #: ______________________ DOB: ______________________

Sex: ☐ Male ☐ Female Email address: ______________________

Home Address: Street ______________________ City ______________________ State ________ Zip ________

Home tel#: ______________________ Work Tel ______________________ Cell #: ______________________

Referring Physician: ______________________ Telephone #: ______________________

Employer Name ______________________

Employer Address: ______________________

Patient Marital Status: ______________________ Name of Spouse: ______________________ DOB: ______________________

Are you currently lying in a skilled nursing facility/ rehab unit: 0 YES 0 NO If yes, please provide the following:

Facility Name: ______________________ Phone #: ______________________

Facility Address: ______________________

IN CASE OF EMERGENCY

Who may we call in case of emergency? Name: ______________________

Relationship to patient: ______________________ Primary Tel #: ______________________ Secondary Tel#: ______________________

BILLING INFORMATION

Name of person responsible for bill (Guarantor): ______________________

Address: Street ______________________ City ______________________ State ________ Zip ________

Home Tel #: ______________________ Work Tel #: ______________________

Guarantor Social Security #: ______________________ DOB: ______________________

Name of employer of guarantor: ______________________

Address: Street ______________________ City ______________________ State ________ Zip ________

INSURANCE INFORMATION

Primary Insurance Carrier: ______________________ State ________ Zip ________-

Address on back of card: Street ______________________ City

Adjuster Name: ______________________ Tel #: ______________________

Secondary Insurance Carrier: (If applicable) ______________________

Address on back of card: ______________________ City ______________________ State ________ Zip ________

Is this visit due to (check one): 0 Personal Injury 0 Auto Accident 0 Work Related

Date of Injury: ______________________

Please list what you are being seen for today: ______________________-

Patient Signature: ______________________ Date: ______________________

FORMULARY BENEFITS AND PRESCRIPTION
DATA CONSENT FORM

Formulary Benefits and Prescription data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit.

Surescripts delivers medication history information across providers during a patient's office visit through electronic prescribing and electronic health record systems that are certified for the Medication History service. The service is made possible by Surescripts' ability to securely access and aggregate patient medication history data from community pharmacies and patient medication claims history from payers and PBM.

Prescribers who can access critically important information on their patient's current and past prescriptions are better infromed about potential medication issues with their patients and can use this information to improve safety and quality. Medication History data can indicate:

- Patient compliance with prescribed regimens
- Therapeutic interventions
- Drug-drug and drug-allergy interactions
- Adverse drug reactions
- Duplicate therapy.

By signing below I give permission for____________________ to access my pharmacy benefits
Clinic Name

data electronically through Surescripts. This consent will enable_____________________ to:
Clinic Name

- Determine the pharmacy benefits and drug copays for my health plan.
- Check whether a prescribed medication is covered (in formulary) wider my plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, c-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for me by any provider.

In summary, you grant permission to obtain formulary information, and information about other prescriptions prescribed by other providers using Surescripts.

_______________________________________ _____________________

Patient Name (Printed) Date of Birth

_______________________________________ _____________________

Patient/Guardian Signature Date

Dear Valued Patient,

In an effort to continue to provide exceptional healthcare services, it is important that Nix Health receive payment for services rendered. In the process of billing and collecting from your insurance provider, there are times when payment is delayed or refused due to the lack of information in their files to show that they are the only insurance carrier providing coverage to you, the beneficiary. A statement from you is required stating that either there is no other coverage or that the reason for this course of treatment was not due to an accident. To prevent any delays, we ask that you complete this form that we can file with your insurance company. This will help you in getting hospital and physician claims paid. We appreciate you taking the time to fill out this form.

Date of Service:	Insurance Company Name:
Patient Name:	Patient Insurance 1D:
Subscriber's Name:	Group Number:
Patient's Relationship to Subscriber:	Subscriber's Birth Date:

☐ I am not covered by any other insurance and have not been injured as a result of an accident.
(Stop here to sign and date the form at the bottom of this page)

Question	Yes	No
1. Are you receiving services today due to the result of an accident?		
2. If you were injured as a result of an accident, was this an accident at your place of employment covered by worker's compensation?		
3. If you were injured as a result of an accident, was this an accident caused by the negligence or intentional misconduct of another person?		
4. Are you covered by any other insurance such as Medicare, Medicaid, TriCare or policies from your employer under a group health plan?		
5. Are you covered under an insurance plan carried by your spouse or family member?		

If you answered Yes to any of the above questions, please provide the information requested below:

Name of Insurance Company: ______________________________

Policy / Group and ID Numbers: ______________________________

Name of Policy Holder (Subscriber): ______________________________

Insurance Company Address: ______________________________

City / State / Zip: ______________________________

Name and address of person responsible for your injuries: ______________________________

The information provided above is complete and correct to the best of my knowledge.

______________________________ ______________________________

Patient Signature Date

Clinic: ________________________ MRN#:__________

MEDICAL RELEASE AUTHORIZATION

I HEREBY AUTHORIZE THE FOLLOWING PEOPLE TO RECEIVE ANY AND ALL TEST RESULTS AND I UNDERSTAND THAT INFORMATION RELEVANT TO HIV TESTING AND/OR AIDS RELATED DIAGNOSIS MAY BE CONTAINED IN THIS INFORMATION.

1.) ______________________________ RELATIONSHIP: ________________________

2.) ______________________________ RELATIONSHIP: ________________________

3.) ______________________________ RELATIONSHIP: ________________________

____ ____________________________

PATIENTS SIGNATURE DATE

I DO NOT AUTHORIZE ANYONE TO RECEIVE ANY TESTS RESULTS OR MEDICAL HISTORY.

PATIENTS SIGNATURE DATE

____ ____________________________

I WILL NOT HOLD THE JESSE DELEE MD OR STAFF RESPONSIBLE FOR RELEASE OF INFORMATION RELATED TO THE ABOVE WITHOUT MY SIGNATURE.

UNDER NO CIRCUMSTANCES CAN ANY CHANGES BE MADE VERBALLY.

____ ____________________________

PATIENT'S SIGNATURE DATE

____ ____________________________

I HEREBY AUTHORIZE ______________________________

Name of Hospital / Facility from which you are requesting

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FROM THE **RECORD OF:**

PATIENT NAME: ______________________________ **TELEPHONE #**: ____________________

SOCIAL SECURITY #:______________________________ DATE OF BIRTH: ____________________

Covering the period(s) of hospital from:

DATE(S) OF **ADMISSION / DISCHARGE:** ______________________________

INFORMATION WILL BE RELEASED TO:______________________________

ADDRESS; ______________________________ **FAX:** ________________ PHONE#: ____________

I HEREBY AUTHORIZE THE FOLLOWING INFORMATION TO **BE DISCLOSED:**

- ☐ Discharge Summary
- ☐ Discharge Instructions
- ☐ History & Physical
- ☐ Psychotherapy Notes
- ☐ Other: ______________________________
- ☐ Operative Report
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Psychiatric valuation
- ☐ Progress Notes
- ☐ Complete Health Record(s)
- ☐Transfer Instructions

PURPOSE(S) OF DISCLOSURE: ☐Continued Medica) Care ☐Legal Purposes ☐Insurance ☐ Other: ______________

I **hereby also consent to the release** of the **following information, which may have specific statutory protection:**

- Information about substance abuse and treatment; mental health information, AIDS/HIV test results diagnosis, treatment or drug test results, and healthcare information received from another healthcare institution.

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that the Nix Healthcare System may not condition treatment on my completion of this authorization form.

I understand that I may revoke this authorization in writing at any time except to the extent that______________________________has already relied on this information. I understand that to revoke this authorization I must do so in writing and present it to the Medical Record Department. **Unless otherwise specified, this authorization shall expire 180 days from the date of signature.**

______________________________ ______________________________

Signature of Patient Date

______________________________ ______________________________

Signature of Parent/Guardian/Legal Representative Date

Knee involved: ☐ Right ☐ Left Date knee problem began: ____________________

Were you hurt on the job? ☐i Yes ☐No Date last worked ____________________

Does your knee problem involve a legal case? ☐ Yes ☐ No

Usual Recreation: ____________________

Have you had problems with your knees before this present problem, such as an injury or surgery? ☐ Yes ☐ No If yes" what were they?

____

What is the biggest problem with your knee?

____

When you injured your knee the first time, did it. . . . IF NO INJURY, SKIP TO NEXT STEP

Pop? ☐ Yes ☐ No
Feel like it slipped out of place? ☐ Yes ☐No
Swell? ☐ Yes ☐No
Were you able to continue to work or play? ☐i Yes ☐No

DO YOU CURRENTLY HAVE ANY OF THE PROBLEMS LISTED BELOW WITH YOUR KNEE?

1. KNEE PAIN? ☐ Yes ☐ No

Location? ☐Front ☐ Side or ☐i Back of Knee
Night pain? ☐ Yes ☐ No
Pain with knee motion? ☐ Yes ☐ No
Pain with squatting? ☐ Yes ☐ No
Pain going up or down stairs? ☐ Yes ☐ No
Pain when you walk? ☐ Yes ☐ No
How far can you walk? ____________________
Pain with weather changes? ☐ Yes ☐No
Pain when the knee is held in a bent position for too long? ☐Yes ☐ No
Constant pain? ☐ Yes ☐No
What relieves the pain? ____________________

2. KNEE SWELLING? ☐Yes ☐ No

3. KNEE POPPING? ☐ Yes ☐ No

4. **DOES IS HURT WHEN** IT **POPS?** ☐ Yes ☐ No

5. **KNEE GRINDING**? ☐Yes ☐ No

6. **KNEE LOCKING** ☐Yes ☐ No
   (This means that you bend your knee and it gets stuck in the bent position and you have to move it to get it to go out straight).

7. **KNEE CATCHING WITH LEG STRAIGHT OUT?** ☐ Yes ☐ No

8. **KNEE SLIPPING OUT OF PLACE?** ☐ Yes ☐No

9. **DOES YOUR KNEE GIVE OUT?** ☐ Yes ☐ No

10. **DOES YOUR KNEE HAVE STIFFNESS**? ☐Yes☐ No

11. **DOES YOUR KNEE EVER HAVE REDDNESS OR FEEL** HOT? ☐i Yes ☐i No

12. **DO YOU EVER HAVE FEVER OR CHILLS WITH YOUR KNEE PROBLEM?** ☐ Yes ☐ No

13. **DO YOU EVER HAVE NUMBNESS OR TINGLING IN YOUR LEGS?** ☐ Yes ☐ No

14. **HAVE YOU EVER HAD AN INFECTION IN ANY OF YOUR JOINTS?** ☐ Yes ☐ No

15. **WHAT DOCTORS HAVE YOU SEEN ABOUT THE PROBLEMS WITH KNEE?**

    ______________________________ ______________________________

    ______________________________ ______________________________

16. WHAT TESTS HAVE YOU HAD DONE ON YOUR KNEES?
    ☐ X-rays ☐ Bone Scan
    ☐MRI ☐CTScan
    LI Nerve testing

17. WHAT TREATMENTS HAVE YOU HAD FOR YOUR KNEE?
    ☐Medications
    ☐Shots in the muscle
    ☐Cortisone shots in the knee. . . . How many? ___________
    ☐Euflexia Injections
    ☐Hyalgen / Synvisc / SuparTz
    ☐Physical Therapy

____

Date