Patient Name (as shown on insurance card): ______________________ Male or Female

Address: ______________________ City: ______________ State: ________ ZIP: ________

Primary phone: ______________ Mobile: ______________ Work: ______________

Social Security Number: ______________ Date of Birth: ______________ Age: ________

Email: ____

Race: ______________ Ethnicity: ______________ Primary Language: ______________

Employer/School: ____

Marital Status: □ Single □ Married □ Widowed □ Divorced

RESPONSIBLE PARTY/INSURED

Legal Name: ______________________ Relationship: ______________

Social Security Number: ______________________ Date of Birth: ______________

Employer: ______________________ Phone: ______________

EMERGENCY CONTACT

Name: ______________________ Relationship to patient: ______________

Address: ______________________ City: ______________ State: ________ ZIP: ________

Primary phone: ______________ Mobile: ______________ Work: ______________

Employer: ____

Employer Address: ____

PLEASE GIVE COPY OF ALL INSURANCE CARDS TO THE FRONT DESK!

Primary Insurance: ____

Policy Holder's name & Date of birth: ______ ______________________________

Secondary Insurance: ____

Policy Holder's name & Date of Birth: ______ ______________________________

I authorize the release of any medical or other information necessary to process this claim.
I understand that services rendered today are my financial responsibility. Insurance is filed as a courtesy to you; there may be a difference between your benefits and fees.
I assign the payment of medical benefits to: Lisa K. Longhofer, MD, PA.

Signature: ______________________________ **Todays Date:** ______________

Relationship (if not the patient): ______________________________

PANHANDLE ORTHO & HAND
LISA K. LONGHOFER, M.D.

PATIENT HISTORY

Patient name: ______________________ Date of Birth: ____________ Today's date: ____ ____

Height: ________ Weight: ________ Who is your Primary Care Physician? ______________________

What is your occupation? ______________________ Hand Dominance: ☐ Right ☐ Left

Do you see any other medical specialist (Cardiologist, etc)? If yes, please list: ______________________

Pharmacy name & address: ______________________

List all current medications and the dose you are currently taking (include non-prescription and supplements)

☐ **NONE** ☐ **LIST ATTACHED**

____

____

____

Please list any known allergies (medications, metals, substances)

☐ **NONE**

____

____

Please rate your pain for today's visit: **0 1 2 3 4 5 6 7 8 9 10**

Location of this pain: ______________________

Date of Injury: ______________________ Result of: ☐ Sports ☐ On the Job ☐ Auto accident

How did the injury occur? ______________________

If on the job injury, is this Workers Comp (have you filed a report with employer)? ☐ YES ☐ NO

Injury Location: ☐ **Right** ☐ **Left**

☐ Shoulder ☐ Elbow ☐ Hand ☐ Hip ☐ Knee ☐ Foot
☐ Arm ☐ Wrist ☐ Finger ☐ Leg ☐ Ankle ☐ Toe

What symptoms are you experiencing?

☐ Locking ☐ Grinding ☐ Catching ☐ Weakness ☐ Popping
☐ Numbness ☐Tingling ☐ Stiffness ☐ Other: ______________________

Have you had any studies or testing for the injury?

☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCV ☐ Other ______________________

Medical History (Please include any medical conditions you are CURRENTLY being treated for)

☐ AIDS/HIV
☐ Alcoholism
☐ Anemia
☐ Drug Abuse
☐ Asthma
☐ Seizures
☐ Alzheimer's
☐ Sleep Apnea
☐ Other medical conditions: ____________

☐ Cancer/Type ____________
☐ COPD
☐ Depression
☐ Diabetes
☐ Kidney Disease
☐ Gout
☐ Ulcers, Bleeding
☐ Thyroid Problems

☐ Blood Clot/Location ____________
☐ Stroke
☐ Heart Disease
☐ Heart Stent
☐ Heart Attack
☐ Coronary artery disease
☐ High Blood Pressure
☐ Blood thinners/Please circle one:
Plavix Coumadin Xarelto Eliquis
Pradaxa Aspirin Other: ________

☐ Osteogenesis Imperfecta
☐ Osteoporosis
☐ Osteopenia
☐ General Arthritis
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Bone Infection
☐ Hepatitis/Please circle one:
A B C

Past Surgeries/Dates: ______________________

____

____

Family History (If family condition exists, please write "father", "mother", or "sibling" after the condition)

- □ AIDS/HIV
- □ Alcoholism
- □ Anemia
- □ Blood Clots
- □ Hemophilia
- □ Kidney Disease
- □ Muscle Disease
- □ Hypertension
- □ Diabetes
- □ Cancer/Type: ____________________
- □ Coronary artery disease
- □ Stroke
- □ Heart Disease
- □ Heart Attack
- □ Liver Disease
- □ Osteoporosis
- □ Osteoarthritis
- □ Gout
- □ Other Medical Conditions: ____________________

Social History (Please indicate use/former use of the following substances)

Tobacco □ **YES** □ **NO** □ **FORMER**

If you checked yes or former:
How many packs per day? ____________ How many years? ____________

Alcohol □ **YES** □ **NO** □ **FORMER**

If you checked yes or former:
How many drinks per day? ____________ Duration: ____________

Caffeine □ **YES** □ **NO**

Illegal Drugs □ **YES** □ **NO** **If yes, please explain:** ____________________

This is extremely important to answer honestly due to the possibility of medication interactions.

Review of Symptoms
Please indicate if you experience any of the following:

Constitutional
- □ Weight Loss/Gain
- □ Weakness
- □ Fatigue
- □ Fever
- □ Have Pacemaker

Cardiovascular
- □ High Blood Pressure
- □ Chest Pain
- □ Rheumatic Fever
- □ Palpitations
- □ Muscular Pain

Musculoskeletal
- □ Joint Pain
- □ Arthritis
- □ Muscular Weakness
- □ Stiffness

Endocrine
- □ Thyroid trouble
- □ Excessive Sweating
- □ Excessive Thirst

Eyes
- □ Glasses/ Contacts
- □ Glaucoma
- □ Blurred Vision
- □ Cataracts
- □ Excessive Tearing

Respiratory
- □ Shortness of Breath
- □ Cough
- □ Wheezing
- □ Asthma
- □ Bronchitis

Skin
- □ Rashes
- □ Sores
- □ Lumps
- □ Dryness
- □ Itching

Hematolymphatic
- □ Easy Bruising
- □ Anemia
- □ Swollen Glands
- □ Easy Bleeding

Ear/Nose/Throat/Mouth
- □ Ringing in the Ears
- □ Earaches
- □ Hearing Aid
- □ Frequent Colds
- □ Nasal Discharge
- □ Hay Fever
- □ Nosebleeds
- □ Dentures
- □ Frequent Sore Throats
- □ Bleeding Gums

Gastrointestinal
- □ Heartburn
- □ Rectal Bleeding
- □ Abdominal Pain
- □ Gallbladder trouble
- □ Hepatitis

Immunologic
- □ Reactions to Drugs
- □ Skin Rashes
- □ Reactions to Foods

Neurologic
- □ Headaches
- □ Dizziness
- □ Vertigo
- □ Seizures
- □ Loss of Sensation

Genitourinary
- □ Blood in Urine
- □ Urinary Infections
- □ Kidney Stones
- □ Burning Urination
- □ STDs

Psychiatric
- □ Nervousness
- □ Depression
- □ Mood Changes

CONSENT FOR TREATMENT: To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

____________________ ____________________

Signature of Patient/Guardian Date

Release of Information

Patient name: ____ Date of Birth: ______________________

Please list the names of any family members, friends, or any others that we may release health information to such as: general medical condition including treatment, prescriptions to be picked up at our office, medical records, school or work notes, etc.

PLEASE NOTE: For children under the age of 18 – to the parent filling out patient paperwork, YOU MUST list the second parent on this form so they will have access to the patient information.

____
Name

____
Name

____
Name

____
Name

____
Name

Signature: ____ **Date:** ____________________________

This Release of Information remains valid until revoked in writing by the above signed individual.

Photo Release Form

Panhandle Ortho & Hand
6907 John David Circle
Amarillo, TX 79124

☐ I **DO** give permission to use the photograph of injury and/or surgical site.

☐ I **DO NOT** give permission to use the photograph of injury and/or surgical site.

Patient name: ____

I grant Panhandle Ortho & Hand, it's representatives and/or employees, the right to photograph injury and/or surgical site. I understand these photographs will not identify me by name or by face. I authorize Panhandle Ortho & Hand, its assignees and transferees, to copyright, use, and publish the same in print and/or electronically.

I agree that Panhandle Ortho & Hand may use such photographs of my injury or surgical site for any lawful purpose, including and for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above.

Signature: ____

____

Representative (if not the patient/if under age 18)

Printed name: ____ **Date:** ______________________

This Photo release form remains valid until revoked in writing by the above signed individual.

FINANCIAL AGREEMENT/RESPONSIBILTY

Dr. Longhofer's services are provided directly to you and you are responsible for payment of all services rendered. As a courtesy, we will submit your claim to the insurance company you have provided us. It is your responsibility to make sure we have correct insurance information and ID numbers AND that we are in network providers for your insurance company.

Office visits/injections
Your co-pay, co-insurance, and/or deductible amounts are due at the time of service. The estimate given prior to services are an estimate only!! Services not covered by insurance are also due prior to services being rendered.

Surgery
Surgery deposits/estimates are required prior to non-emergent procedures and are due 3 days before your surgery. Our deposits/estimates are based on your current benefits and may vary depending on the actual surgery/procedure and how your insurance processes the claim. Please remember these are estimates only!

If claims for services provided by Dr. Longhofer are denied by your insurance company, you are responsible for payment. Responsibility for payment begins on the date that services are provided.

Workers Compensation
Dr. Longhofer is not currently taking worker's comp; however, this will be assessed on a case by case basis. Your recovery and return to work take a partnership with you, your case manager/adjustor and us. If you claim is denied, charges with be your responsibility.

Account Balances
If you have a balance remaining after your insurance carrier has paid and for patients without insurance, we offer the following options:

Payments are accepted by cash, check or most credit cards.

Short term payment plan may be available BUT will not exceed three months. **ALL BALANCES MUST BE PAID IN FULL WITHIN 3 MONTHS FROM FIRST STATEMENT MAILED.**

Accounts with remaining balances where no resolution has been made in a timely fashion may be turned over to a collection agency.

I understand the above financial agreement and that I am financially responsible for payment of medical charges incurred.

Signature: ______________________________ **Date:** ____________________

6907 John David Circle
Amarillo, TX 79124
Phone (806) 358-0600 Fax (806) 358-0601

This acknowledgement of our financial policy remains valid until revoked in writing by the above signed individual

Acknowledgement of Receipt of Notice of Privacy Practices

I ______________________________________, acknowledge that I have received a copy of the Privacy Practices for Dr. Lisa K. Longhofer, MD.

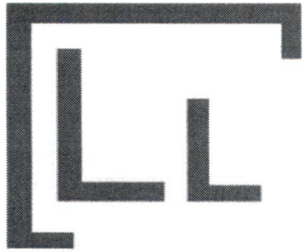
Patient signature: ____ **Date:** ____________________

Representative: ____ **Date:** ____________________
(if not patient/if under age 18)

Printed name of legal representative: ____

Relationship to patient: ____

This acknowledgement of Receipt of the privacy practices remains valid until revoked in writing by the individual who has signed the above form.



PANHANDLE
ORTHO & HAND
LISA K. LONGHOFER, M.D.

ORTHOPAEDIC SURGERY | HAND & UPPER EXTREMITY SPECIALIST

Panhandle Ortho and Hand COVID-19 Summary and Disclaimer

As dedicated healthcare providers who are complying to the CDC guidelines during the global pandemic, COVID-19, we are only seeing patients of medical necessity at this time. We are diligently working to do our part in preventing the spread of COVID-19. We are asking that for the safety of our patients and our staff that if you are experiencing any cold or flu-like symptoms that you cancel your appointments until you are symptom free for two weeks. In addition, we are asking that patients who have recently traveled outside the Amarillo or other designated homestead area that you wait 14-21 days after your return before scheduling any appointments.

We understand that the decision to postpone treatment or a procedure is not an easy one. Our goal is to be here for our patients and to continue care without disruption. We are working diligently to keep our patients and staff safe. Therefore, we ask that you consider postponing your treatment if you or a family member within your household fall into any of the following categories:

- You are presently symptomatic or have recently experienced symptoms, including but not limited to:
- Flu like symptoms
- Fever
- Chills
- Sore throat
- Cough or Shortness of breath
- You recently (within the past 14-21 days) traveled outside the Amarillo or other designated homestead area or have had exposure to a person who has returned from outside the country withing the past 14-21 days.

If you have any of the following symptoms, we ask that you let our staff know immediately. We appreciate your understanding and cooperation during these difficult times.

Thank you,

Dr. Longhofer and Staff

COVID-19 Waiver, Release of Liability and Assumption of Risk

In consideration of the risk of infection during the global pandemic of COVID-19, I, the undersigned, and/or on behalf of any minor receiving treatment for which I am the legal guardian (collectively, "Patient"), as a patient of Panhandle Ortho and Hand ("POH"), hereby expressly agree to the following:

I assume all risk and possible outcomes of receiving medical treatment by POH during a global pandemic.

I hereby authorize that I am willing to receive medical treatment by POH, due to the medical necessity of my appointment.

I confirm that I do not have any symptoms of COVID-19 or have been exposed to anyone else with symptoms of COVID-19. I further confirm I have reviewed and understand page one containing a list of symptoms associated with COVID-19.

I confirm that I have not been in contact with or exposed to any individuals of a positive COVID-19 status or COVID-19 like symptoms.

I confirm that I have not traveled outside the Amarillo area or designated homestead in the past 14-21 days.

I confirm that I have received and understand the Panhandle Ortho and Hand COVID-19 Summary and Disclaimer.

I confirm that I am of sound mind and full understanding of the risks that I am assuming by seeking medical treatment during a global pandemic. I am aware of the Executive Order that has been issued during this pandemic and confirm that I am comfortable proceeding with medical treatment. I hereby authorize my consent for treatment and accept all possible risk that may be included in this pandemic. I hereby waive, discharge and release POH or its owners, agents, employees, officers, partners, representatives, assigns, members, parents, subsidiaries, affiliated organizations, insurers and others acting on POH's behalf ("Associates"), of all legal liability, claims, demands, and causes of action, including negligence, gross negligence, and strict liability, that I may have for any and all damages and injuries to Patient or Patient's minor children, whether the same be known or unknown, anticipated or unanticipated, and related to the global pandemic of COVID-19. I will not sue or bring any claims, demands, legal actions and/or causes of action against POH or its Associates, for any economic or non-economic losses due to bodily injury or death related to COVID-19, sustained by Patient in relation to Patient's treatment by POH or its Associates.

I, BY SIGNING BELOW, AGREE THAT I (A) HAVE READ AND VOLUNTARILY SIGN THIS RELEASE; (B) UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT; (C) HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE OR GUARANTEE; AND (D) INTEND THAT MY SIGNATURE IS A COMPLETE AND UNCONDITIONAL ASSUMPTION OF RISK AND RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW.

____

Date: ______________________________

Printed Name: ______________________________

Signature: ______________________________

COVID-19 Disclaimer for Injections and In Office Procedures

At this time, Panhandle Ortho and Hand is still offering procedures, such as steroid injections and in office procedures that comply with current CDC, WHO and local health department guidelines. However, the decision of the medical necessity of a steroid injection or in office procedure is up to the discretion of the treating physician. This decision is on a case-by-case basis of each patient based on their medical history and medical necessity.

Although there is no direct evidence that would suggest a link between an increased risk of contracting COVID-19 with the administration of corticosteroid injections; there have been studies that prove a possible reduction of the immune response for a few weeks following the administration of corticosteroids. It is important to know that although the risk for increased infection rates is extremely low, it must be considered before deciding whether to proceed with your procedure

The CDC, WHO and local health departments are diligently working to uncover more details on COVID-19. Do be aware that as dedicated healthcare providers who are complying with the CDC guidelines during the global pandemic, COVID-19, we at Panhandle Ortho and Hand may have to make changes to scheduled office visits, as well as designating which procedures we are able to perform. We ask that you please understand these policies will be put in place to protect you as well as those you come in close contact with, and our office staff. Should you develop symptoms following a procedure or office visit, we ask that you contact our office at (806) 358-0600 immediately just as you would have before COVID-19.

I, the undersigned, and/or on behalf of any minor receiving treatment for which I am the legal guardian (collectively, "Patient"), as a patient of Panhandle Ortho and Hand ("POH"), hereby expressly agree to the following:

I authorize any in office procedures or corticosteroid injections that may be deemed medically necessary and understand the above risks and possible unknown risks that could potentially occur.

I confirm that I am of sound mind and full understanding of the risks that I am assuming by seeking medical treatment during a global pandemic. I am aware of the Executive Order that has been issued during this pandemic and confirm that I am comfortable proceeding with medical treatment. I hereby authorize my consent for treatment and accept all possible risk that may be included in this pandemic. I hereby waive, discharge and release POH or its owners, agents, employees, officers, partners, representatives, assigns, members, parents, subsidiaries, affiliated organizations, insurers and others acting on POH's behalf ("Associates"), of all legal liability, claims, demands, and causes of action, including negligence, gross negligence, and strict liability, that I may have for any and all damages and injuries to Patient or Patient's minor children, whether the same be known or unknown, anticipated or unanticipated, and related to the global pandemic of COVID-19. I will not sue or bring any claims, demands, legal actions and/or causes of action against POH or its Associates, for any economic or non-economic losses

due to bodily injury or death related to COVID-19, sustained by Patient in relation to Patient's treatment by POH or its Associates.

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____

Date: ______________________________

Printed Name: ______________________________

Signature: ______________________________

PANHANDLE ORTHO & HAND
LISA K. LONGHOFER, M.D.

ORTHOPAEDIC SURGERY | HAND & UPPER EXTREMITY SPECIALIST

Panhandle Ortho and Hand COVID-19 Surgery Disclaimer

As dedicated health care professionals, Panhandle Ortho and Hand, is following the guidelines of the CDC, WHO and local health department guidelines on what surgical procedures may be performed. At this time, Panhandle Ortho and Hand is only preforming surgeries that are deemed emergent or medically necessary by the treating physician. The decision for a surgery to be performed is up to the discretion of the treating physician. This decision is on a case-by-case basis of each patient based on their medical history and medical necessity.

The CDC, WHO and local health departments are diligently working to uncover more details on COVID-19. Do be aware that as dedicated healthcare providers who are complying to the CDC guidelines during the global pandemic, COVID 19, we at Panhandle Ortho and Hand may have to make changes to scheduled office visits, as well as designating which procedures we are able to perform. We ask that you please understand these policies will be put in place to protect you as well as those you come in close contact with, and our office staff. Should you develop symptoms following a procedure or office visit, we ask that you contact our office at (806) 358-0600 immediately just as you would have before COVID-19.

We understand that the decision to postpone or cancel a surgical procedure is not an easy decision to make. Our goal in this difficult time is to keep our staff and patients safe while maintaining the highest level of care possible. Therefore, we are asking that any surgical procedures be postponed if you have any of the symptoms of COVID-19 or have been exposed to someone with symptoms like COVID-19. Please see the Summary and Disclaimer for further information.

If you have been advised by the treating physician that a surgical procedure is needed, please note that this is because the risk of not performing surgery is greater than any possibility of increased exposure.

I, the undersigned, and/or on behalf of any minor receiving treatment for which I am the legal guardian (collectively, "Patient"), as a patient of Panhandle Ortho and Hand ("POH"), hereby expressly agree to the following:

I authorize any surgical procedures that may be deemed medically necessary and understand the above risks and possible unknown risks that could potentially occur.

I confirm that I am of sound mind and full understanding of the risks that I am assuming by seeking medical treatment during a global pandemic. I am aware of the Executive Order that has been issued during this pandemic and confirm that I am comfortable proceeding with medical treatment. I hereby authorize my consent for treatment and accept all possible risk that may be included in this pandemic. I hereby waive, discharge and release POH or its owners, agents, employees, officers, partners, representatives, assigns, members, parents, subsidiaries, affiliated organizations, insurers and others acting on POH's behalf ("Associates"), of all legal liability, claims, demands, and causes of action, including negligence, gross negligence, and strict liability, that I may have for any and all damages and injuries to Patient or Patient's minor children, whether the same be known or unknown, anticipated or unanticipated, and related to the global pandemic of COVID-19. I will not sue or bring any claims, demands, legal actions and/or causes of action against POH or its Associates, for any

economic or non-economic losses due to bodily injury or death related to COVID-19, sustained by Patient in relation to Patient's treatment by POH or its Associates.

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____

Date: ______________________________

Printed Name: ______________________________

Signature: ______________________________