ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

PATIENT HISTORY QUESTIONAIRE
Orthopaedic Associates, L.L.P.
Please Print

Patient Name:____**Date:**________________

Date of Birth:___________**Age:**_____**Height:** __________ **Weight:** _________**Occupation:**_________________________

Date of Injury or when did you first notice the problem:____

Type of Injury/Illness:____

Were you injured on the job? **Yes** **No**

What is your current job description/duties:____

____

____

History of present Illness/injury (how did it happen?):____

____

____

Have you had any previous treatment or tests for this problem? **Yes** **No**

If yes, please list what test or treatment have been performed: ____

____

____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

High Blood Pressure	Yes	No	Cancer	Type______________	No
Elevated Cholesterol	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Emphysema/COPD	Yes	No
Asthma	Yes	No	Liver or Kidney Disease	Yes	No
Peptic Ulcers	Yes	No	Bleeding Disorder	Yes	No
Heart Disease	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Osteoporosis	Yes	No			

DO YOU HAVE A FAMILY HISTORY OF:

High Blood Pressure	Yes	No	Emphysema/COPD	Yes	No
Elevated Cholesterol	Yes	No	Liver or Kidney Disease	Yes	No
Diabetes	Yes	No	Bleeding Disorder	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Peptic Ulcers	Yes	No	Arthritis	Yes	No
Thyroid	Yes	No	Hepatitis	Yes	No
Heart Disease	Yes	No	Cancer	Type______________	No
Osteoporosis	Yes	No			

PLEASE LIST PREVIOUS SURGERIES:

____ ____

____ ____

____ ____

PLEASE LIST MEDICATIONS YOU PRESENTLY ARE ON (Including dosage and strength):

____ ____

____ ____

____ ____

Are you Allergic to any Medications? **Yes** **No**

If yes, please list all allergies and type of reaction:____

Do you Smoke? **Yes** **No** **If yes, how often?:**______________________________________

Do you drink alcohol? **Yes** **No** **If yes, how often?:**______________________________________

Do you take any illicit drugs? **Yes** **No**

Patient Signature:____

ORTHOPAEDIC ASSOCIATES, L.L.P.
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Questionario de Historia Medica de Paciente

Nombre de Paciente:_______________________________________Fecha________________
Fecha de nacimiento_____Edad:______Estatura:____Peso:_______Ocupacion:________
Fecha que noto el prolema o que fue lesionado:_______________________________________
Que tipo de lesion tiene o historia del prolema:_______________________________________
Fue lesionado en el trabajo? SI O NO
Que se son las descripiciones de su Trabajo:____
____
Historia del prolema que tiene en este momento:_______________________________________
____
____
Ha tenido usted tratamientos o examenes para este prolema? SI O NO
Si ha tenido tratamientos o examenes por favor listelos:_______________________________
____

TIENE O HA TENIDO ESTOS PROLEMAS MEDICOS:

Alta Presion	SI	NO	Cancer: Tipo:__________		NO
Cholestrol Alto	SI	NO	Ateque al Corzaon	SI	NO
Diabetis	SI	NO	Enfisema	SI	NO
Asthma	SI	NO	Enfermedad de higado o riñón	SI	NO
Ulceras	SI	NO	Trastornos Hemorragicos	SI	NO
Enfermedad del Corazon	SI	NO	Artritis	SI	NO
Latiroides	SI	NO	Hepatitis	SI	NO
Osteoporosis	SI	NO			

TIENEN HISTORIA EN SU FAMILIA:

Alta Presion	SI	NO	Cancer: Tipo:__________		NO
Cholestrol Alto	SI	NO	Ateque al Corzaon	SI	NO
Diabetis	SI	NO	Enfisema	SI	NO
Asthma	SI	NO	Enfermedad de higado o riñón	SI	NO
Ulceras	SI	NO	Trastornos Hemorragicos	SI	NO
Enfermedad del Corazon	SI	NO	Artritis	SI	NO
Latiroides	SI	NO	Hepatitis	SI	NO
Osteoporosis	SI	NO			

PORFAVOR LISTE LAS CIRUGIAS QUE A TENIDO EN EL PASADO:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

PORFAVOR LISTE LAS MEDICINAS QUE ESTA TOMANDO:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Es Alergico a algun tipo de medicina: SI NO
Si contesto si, porfavor cual es el nombre de la medicina? Que reaccion tuvo?
____
Usted fuma? SI NO SI contesto si cuanto?______________________
Bebe Alcohol? SI NO SI contesto si cuanto?______________________
Toma usted drogas ilegales? SI NO SI contesto si cuanto?______________
Firma del Paciente:____

ORTHOPAEDIC ASSOCIATES, L.L.P.
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
DAVID L. LIN, M.D.
WASYL FEDORIW, M.D.
KAKU BARKOH, M.D.
AMY E. RIEDEL, D.P.M.

CONSENT FOR TREATMENT

This facility has on staff a physician in the delivery of medical (Orthopaedic) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the Supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training and experience. The services may include:

A. Obtaining histories and performing physical exams
B. Ordering and/or performing diagnosis and therapeutic procedure
C. Formulating a working diagnosis
D. Developing and implementing a treatment plan
E. Monitoring the effectiveness of therapeutic interventions
F. Assisting at surgery
G. Offering counseling and education
H. Supplying sample medications and writing prescriptions (where allowed by law)
L. Making appropriate referrals

I have read the above, and hereby consent to the services of a physician's assistant for my health care needs.

I understand that at any time I can refuse to see the physician's assistant and request to see a physician.

Name (please print) ____

Signed_______________________________________Date ______________

ADVANCE BENEFICIARY NOTICE (ABN)
For the Services of a Physician Assistant

Welcome to Orthopaedic Associates, LLP, where we are committed to providing the most advanced, world-class orthopedic medical and surgical care in a comfortable, caring environment. The following is a statement of our ABN for the services of a Physician Assistant (PA), which we request you read and sign before receiving treatment.

USE OF PHYSICIAN ASSISTANTS:

Physician Assistants (PA's) are specially trained medical professionals who assist a surgeon during an operation. The surgeons of this practice commonly use PAs during surgery. The purpose of this notice is to provide you with information regarding billing for this service. The surgeons of this practice feel strongly that PA's are a medical necessity for many surgical procedures. Potential benefits of PA's include improved surgical site exposure, decreased operative time, and decreased blood loss.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN):

Unfortunately, many health insurance carriers are now declining to pay for the use of PAs during surgery. Your insurance carrier may deny payment for a PA because they choose to consider the PA as not medically necessary or because they consider it a non-covered service (your insurance is not required to cover all services you may require). Medicare has published guidelines on procedures for which they will and will not pay for a PA. We adhere to these Medicare guidelines because they are meant to ensure patient safety, increase operating room efficiency, and improve outcomes. Although we choose to adhere to these guidelines, your insurance company is not required to do so. Therefore, to provide you with the high standard of care that you deserve, your treating surgeon has determined that the use of a PA is necessary for your upcoming surgery. We ask that you review the notice, follow the instructions below and return this form to our representative.

Check only one box. We cannot choose a box for you.

☐ Option 1: I understand that I must pay a $350.00 (non-spine, non-revisioin) or $600.00 (spine, revision) non-refundable good-faith estimate for this service before my surgery. I also understand that the charge for this service will be billed to my insurance company. However, if my insurance carrier does not pay for this service, there will be no additional charge to me for this service.

☐ Option 2: I don't want the services of the Physician Assistant listed above. I understand my treating surgeon has determined that the use of a PA is necessary for my upcoming surgery, and my refusal to use a Physician Assistant may alter his/her decision to go ahead with the surgery.

ACKNOWLEDGEMENTS

My signature below constitutes acknowledgment that the use of a Physician Assistant in surgery has been satisfactorily explained to me in terms that I understand.

- I understand and agree that I am ultimately responsible for full payment of services
- I understand that this ABN for the services of a physician assistant shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing
- I have read and fully understand the ABN for the services of a Physician Assistant
- If I have any questions about my charges, statements, or balance due, I will contact the Financial Counselor at (713) 650-6900 Ext. 449

Patient/Guarantor Signature: ________________________________ Date: ___________________________

Orthopaedic Associates, LLP

Surgical Assistant Fee Policy

Orthopaedic Associates, L.L.P. has been in the business of providing quality orthopaedic care since 1950. It is our goal to always provide the best care possible and our staff works very closely with you before your surgery, acting as the liaison and patient advocate with the hospital and your insurance company. We work very diligently to obtain all of the necessary precertification and approvals and talk with you about your estimated out of pocket expenses prior to your surgery. We believe that you will find your experience with our office staff and healthcare providers an excellent one.

With all of the new changes that are occurring with the healthcare system, we have found recent challenges regarding reimbursements with respect to the surgical assistant fee that we charge. Due to this recent challenge, we have been forced to change our policy with respect to the surgical fee that is charged. Not all insurance companies reimburse for the services provided by the surgical assistant. As the orthopaedic procedure you are about to undergo is a technically challenging one, a well-trained surgical assistant is necessary to provide the highest quality of care and give you the successful surgical results that we have been able to do for more than half a century. Accordingly, we will now collect the surgical assistant fee for our surgical assistant prior to the surgery. This fee will be $350 for primary joint replacement and $600 for revision surgery for any patients with conditions that require additional medical assistance such as obesity.

Customarily, we will bill your insurance company for the assistant fees in an effort to obtain payment. If your insurance company pays all or part of the surgical assistant fee, we will reimburse you for the fee that you paid or a portion thereof.

Our physician assistants are very important to the success of each surgery in which they provide assistance. The assistant fees also encompass the postoperative care, which is considered global, just like the surgeon fees. They are vital to the success of your procedure. They are currently in good standing with the American Academy of Physician Assistants, Texas Academy of Physician Assistants, and National Commission on Certification of Physician Assistants.

The doctor’s secretary is available to go over any questions you may have as a result of this correspondence or any other matter affecting your care. Thank you for your understanding in this manner.

By signing below, I state that I have read the above policy and agree to pay the surgical assistant fee as described above and further understand that if my insurance company pays the fee I will be reimbursed.

____

Patient Signature

____

Date

VIVEK P. KUSHWAHA, M.D.
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Orthopaedic Associates, L.L.P.

I understand______________________________________may require a Physician Assistant to assist in my surgery, and in consideration for receiving medical services provided pursuant to my health insurance policy, I assign payment of my insurance benefits directly to Orthopaedic Associates, L.L.P. for the surgical assist services provided.

In the event that my health insurance plan refuses to pay for Physician Assistant surgical assist services, I also assign all my ERISA* rights to a full and fair review process to Orthopaedic Associates, L.L.P. for any and all paid, partially paid or denied surgical assist claims.

I give consent to release medical information to Orthopaedic Associates, L.L.P. or its designated representative. I give consent to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to release medical information to Orthopaedic Associates, L.L.P. or its designated representative to send medical information, as necessary, to my insurance plan.

**ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed insurance claims according to ERISA regulations.*

Patient / Guardian printed name: ____

Patient / Guardian signature: ____

Date: __________________________________

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CONSENT FOR RADIOGRAPHS/INJECTION

I,________________________________hereby authorize Orthopaedic Associates and staff to perform radiographs of my____________________________.

I,________________________________hereby authorize Orthopaedic Associates and staff to give an injection in my____________________________.

Signed____Date ________________

VIVEK KUSHWAHA, M.D.

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FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a “surgery”, but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

___________________________________ ____________________
Patient/Guarantor Signature Date

ORTHOPAEDIC ASSOCIATES, LLP • FINANCIAL POLICY

WELCOME, and thank you for choosing Orthopaedic Associates, L.L.P. for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Orthopaedic Associates, L.L.P. at the time of service. O.A. will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles or fees for non-covered services are required at the time of service.

HMO/ PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with an O.A. physician; it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals.
We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

IF YOU DON'T HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call our billing office at 888-330-1737 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday.

MEDICARE: If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P. will file Medicare and any supplemental insurance claims to your insurance carrier(s).

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature____Date________________

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ORTHOPAEDIC ASSOCIATES, L.L.P. to release any information acquired in the course of my treatment that may be necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC ASSOCIATES, L.L.P.

Patient Signature____Date________________

ANESTHESIA AND HOSPITAL BILLS

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-rays. Questions concerning such bills should be directed to the office of the physician who sent the bill.
Patient Signature____Date________________

USE OF A PHYSICIAN ASSISTANT OR CO-SURGEON

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.
Patient Signature____Date________________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature____Date________________

Orthopaedic Associates, L.L.P

<u>Contract for Opioid Therapy</u>

Our policy regarding the prescription of opioids for nonmalignant pain is strict and non – negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

Our objective when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, and Norco) for chronic pain conditions.

2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.

3. No refills will be made after clinic hours and on weekends or holidays.

4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship in OA.

5. I will not share my medications with anyone.

6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances an exception will be made (i.e. your house burns down or you have a police report).

7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.

8. While being a patient at OA, I will not receive prescriptions for opioids or other sedatives from any other licensed physician, unless it is authorized by OA. Any evidence of such will result in termination of the patient-physician relationship in OA.

9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship in OA.

10. I will use only **1 (one)** pharmacy to fill my medication.

11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician’s request. Failure to do so will result in termination of the patient-physician relationship in OA.

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship in OA.

13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.

14. I understand that physical **dependence** is normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.

15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.

16. I am aware that the use of opioids has been associated with the following side effects:

    - Sleepiness and drowsiness
    - Nausea
    - Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic reaction
    - Slow breathing/Slow reflexes and reaction times
    - Low testosterone levels in males

17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.

18. Overdose of this medication may cause **death** by stopping my breathing.

19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give ORTHOPAEDIC ASSOCIATES, L.L.P. my consent for the treatment of pain with opioid medications.

20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: ____

Patients Signature:____Date Signed: ______________

Pharmacy:____Phone #: ____________________________

UNIVERSAL CONDITION, INJURY/ACCIDENT STATEMENT FORM

ALL BOXES MUST BE COMPLETED BEFORE SEEING A PHYSICIAN

PATIENT NAME:**____*****TODAY'S DATE:*****_______/______/______**

PLEASE COMPLETE THE FOLLOWING STATEMENTS. MOST INSURANCE COMPANIES REQUEST ACCIDENT DETAILS. THIS INFORMATION MAY BE FORWARDED WITH YOUR INSURANCE CLAIM OR PROVIDED TO AN ADJUSTER TO COMPLETE YOUR CLAIM.
WE MUST HAVE "*BOX 1: CONDITION OR DATE OF INJURY*" COMPLETED TO FILE YOUR CLAIM.

1. Please check: ☐ CONDITION ☐ INJURY INJURY DATE:_____/_____/_____(ON OR ABOUT)

THIS DATE IS REQUIRED FOR INSURANCE FILING

How did the injury or pain occur, what were you doing? (Brief Summary)____

____

2. Did the injury occur during work? ☐ YES ☐ NO
3. Were you clocked in? ☐ YES ☐ NO
4. Were you at lunch? ☐ YES ☐ NO

THIRD PARTY LIABILITY

5. Is there a possible third party liability? ☐ YES ☐ NO

(INJURY OCCURRED SOMEWHERE OTHER THAN HOME OR WORK? SUCH AS AUTO, HOMEOWNER'S PROPERTY, ETC.?)

IF YES, A letter of subrogation should be provided before seeing the physician. Your health insurance may deny the claim if the letter is not obtained.

I certify that this information to be true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a **"non-covered"** service and may make me personally liable for the charges incurred.

SIGNATURE:**____*****TODAY'S DATE:*****_______/______/______**

(RESPONSIBLE PARTY)

VIVEK P. KUSHWAHA, M.D.
ALAN J. RECHTER, M.D.
NAVIN SUBRAMANIAN, M.D.
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NOTICE OF PRIVACY PRACTICES

I have reviewed ORTHOPAEDIC ASSOCIATES, L.L.P.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature____Date__________________

I hereby give authorization to Orthopaedic Associates, L.L.P. to release any or all of my information regarding my medical records to a designation of my choice:

Name____Relationship to Patient__________________

MEDICARE PATIENTS

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature____Date__________________

The Physicians believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, they have provided notification that they hold partial ownership interest in:

Grand Texas Surgery Center, PLLC and HHS Joint Venture
Health Scripts Pharmacy
Houston Metro & Ortho Surgery Center
Houston Methodist Hospital
Kingwood Medical Center
Oak Bend Medical Center
Park Ten Surgery Center
St. Joseph Hospital

By my signature below, I hereby acknowledge that I have received notification of Physician's ownership interests.

Patient Signature____Date__________________

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Orthopaedic Associates, LLP
No Show/Cancellation Policy

Orthopaedic Associates, LLP strives to provide each and every patient with personalized care and attention throughout their scheduled appointment time. In order to maintain this high level of care, it is very important that all patients attend their scheduled appointment time. If an appointment is scheduled but not attended, it takes a valuable appointment time away from other patients who have made it a priority to work towards their goals.

"No Show" is missing a scheduled appointment without notification 24 hours prior to that appointment to inform OA, LLP. A "cancellation" is canceling a scheduled appointment without giving 24 hours' notice. A "reschedule" is calling 24 hours prior to a scheduled appointment to change that appointment to a different time or day because of a conflict.

If a patient "No Shows" the following fee schedule will be charged and will need to be paid prior to being seen in our office.

- **Office Visit - $25.00**
- **Worker's Comp/Physical Therapy - $50.00**
- **MRI - $100.00**
- **MRI Worker's Comp - $200.00**

We understand true medical emergencies do occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

I have read and understand Orthopaedic Associates, LLP Services, No Show, Cancellation, and Rescheduling Policies and Procedures.

Patient Signature________________________Date______________________________________