

ORTHOPAEDIC HISTORY

NAME: _____

DATE: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

RIGHT HANDED LEFT HANDED

CHIEF COMPLAINT (What hurts?): Right Left Bilateral Knee Shoulder Other: _____

IF BILATERAL; which side hurts worse?: _____

IF MULTIPLE COMPLAINTS; rank them and pick the one you would like to address at today's visit: _____

DATE OF ONSET OF SYMPTOMS or DATE OF INJURY: _____

DESCRIBE YOUR CURRENT PROBLEM / HOW DID IT OCCUR? (be specific): _____

Where did you first notice the problem? Home Work Other: _____

How did problem begin? No injury. Pain started out of the blue. Slip and fall Twisting injury Playing sports
 Car accident Other (please describe): _____

Are you working? Yes No Full duty Light duty

WHY EXACTLY ARE YOU SEEING THE DOCTOR TODAY? In other words, what do you hope to get from today's visit? (CHECK all that apply)

anti-inflammatories pain medicine a cortisone injection a brace physical therapy MRI to discuss a prior MRI
 work excuse second opinion information on a particular treatment option to discuss and schedule surgery other: _____

WHAT SYMPTOMS ARE YOU HAVING RELATED TO YOUR CURRENT PROBLEM: (CHECK all those that apply)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> PAIN WITH STANDING OR WEIGHTBEARING | <input type="checkbox"/> SWELLING |
| <input type="checkbox"/> PAIN WITH WALKING, JUMPING, OR RUNNING | <input type="checkbox"/> POPPING |
| <input type="checkbox"/> PAIN WITH PROLONGED SITTING | <input type="checkbox"/> LOCKING |
| <input type="checkbox"/> PAIN DURING ACTIVITY <input type="checkbox"/> PAIN AFTER ACTIVITY | <input type="checkbox"/> CATCHING |
| <input type="checkbox"/> PAIN WITH STAIRS (<input type="checkbox"/> WORSE UP <input type="checkbox"/> WORSE DOWN) | <input type="checkbox"/> GRINDING |
| <input type="checkbox"/> PAIN GETTING IN & OUT OF A CAR | <input type="checkbox"/> GIVING WAY |
| <input type="checkbox"/> PAIN WITH SQUATTING OR BENDING | <input type="checkbox"/> INSTABILITY |
| <input type="checkbox"/> PAIN MOVING SIDE TO SIDE OR CHANGING DIRECTION | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> PAIN WITH OVERHEAD ACTIVITY | <input type="checkbox"/> TINGLING |
| <input type="checkbox"/> PAIN REACHING BEHIND YOUR BACK | <input type="checkbox"/> STIFFNESS |
| <input type="checkbox"/> PAIN LYING ON THE AFFECTED SIDE | |
| <input type="checkbox"/> PAIN: <input type="checkbox"/> AT NIGHT <input type="checkbox"/> AT REST | |
| <input type="checkbox"/> CHECK ONE: PAIN IS: <input type="checkbox"/> CONSTANT <input type="checkbox"/> INTERMITTENT | <input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> CHECK ONE: PAIN IS: <input type="checkbox"/> BETTER <input type="checkbox"/> WORSE <input type="checkbox"/> UNCHANGED | <input type="checkbox"/> BRUISING |
| <input type="checkbox"/> CHECK APPLICABLE: PAIN IS: <input type="checkbox"/> DULL <input type="checkbox"/> SHARP <input type="checkbox"/> THROBBING | <input type="checkbox"/> LIMPING |

RATE YOUR PAIN USING THE FOLLOWING SCALE: (0 = NO PAIN; 10 = EXCRUCIATING PAIN)

Circle the number which best applies to your **current pain level**: 0 1 2 3 4 5 6 7 8 9 10

If the current problem is the result of one of the following, please **CHECK** all those that apply:

CAR ACCIDENT: DRIVER PASSENGER BELTED UNBELTED REARENDED SIDE IMPACT
AIRBAGS: YES NO HEAD TRAUMA: YES NO
CAR TOTALLED: YES NO LOSS OF CONSCIOUSNESS: YES NO

SPORTS INJURY: CONTINUED PLAYING AFTER INJURY UNABLE TO PARTICIPATE AFTER INJURY
 IMMEDIATE SWELLING HEARD A "POP" FELT A "POP"

HAVE YOU SOUGHT MEDICAL ATTENTION FOR THIS PROBLEM OR A SIMILAR PROBLEM BEFORE? No Yes
IF YES, By whom? _____ **DID YOU RECEIVE ANY PRIOR TREATMENT?** No Yes

TREATMENT RECEIVED (please **CHECK** all those that apply): TYLENOL ADVIL MOTRIN ALEVE PRESCRIPTION PAIN MEDICINE CORTISONE INJECTION ICE ACE BRACE SLING SPLINT CRUTCHES X-RAYS MRI PHYSICAL THERAPY CHIROPRACTOR SURGERY GLUCOSAMINE CHONDROITIN OTHER: _____

MANN ORTHOPAEDICS
2500 Fondren Road, Suite 300 Houston, Texas 77063

PAST MEDICAL HISTORY: (please **CHECK** all those that apply) **NEGATIVE**

- | | | | | | |
|--|--|--|---|--|--|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> BLOOD CLOTS |
| <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIABETES | <input type="checkbox"/> DIALYSIS | <input type="checkbox"/> DIVERTICULITIS | <input type="checkbox"/> EMPHYSEMA |
| <input type="checkbox"/> GI BLEED | <input type="checkbox"/> GOUT | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> HEART FAILURE |
| <input type="checkbox"/> DEMENTIA | <input type="checkbox"/> PARKINSON'S | <input type="checkbox"/> MITRAL VALVE | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEPATITIS A |
| <input type="checkbox"/> HEPATITIS B | <input type="checkbox"/> HEPATITIS C | <input type="checkbox"/> HIV <input type="checkbox"/> AIDS | <input type="checkbox"/> STROKE / TIA | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> HYPERTHYROID |
| <input type="checkbox"/> HYPOTHYROID | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> ULCERS | <input type="checkbox"/> HIATAL HERNIA | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> VARICOSE VEINS | <input type="checkbox"/> LUPUS | <input type="checkbox"/> LYME DISEASE | <input type="checkbox"/> POOR CIRCULATION | <input type="checkbox"/> RHEUMATOID |
| <input type="checkbox"/> PSORIASIS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> STAPH INFECTION | <input type="checkbox"/> URINARY INFECTION | <input type="checkbox"/> SLEEP APNEA |
| <input type="checkbox"/> PULMONARY EMBOLUS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> OTHER: _____ | | | |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> If yes; what major bone and when? _____ | | | | |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> If yes; what type & what treatment? _____ | | | | |
- ANY HOSPITALIZATIONS?** No Yes Describe: _____

PAST SURGICAL HISTORY: (please **CHECK** all those that apply) **NEGATIVE**

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> CATARACTS (L / R) | <input type="checkbox"/> LASIK EYE (L / R) | <input type="checkbox"/> DENTAL | <input type="checkbox"/> TONSILLECTOMY | <input type="checkbox"/> CARDIAC BYPASS |
| <input type="checkbox"/> PACEMAKER / STENT | <input type="checkbox"/> DEFIBRILLATOR | <input type="checkbox"/> VASCULAR SURGERY | <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> HERNIA REPAIR |
| <input type="checkbox"/> GALLBLADDER | <input type="checkbox"/> EXPLORATORY LAP | <input type="checkbox"/> GASTRIC BYPASS | <input type="checkbox"/> LAP BAND | <input type="checkbox"/> KIDNEY |
| <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> C-SECTION | <input type="checkbox"/> BLADDER LIFT | <input type="checkbox"/> COLONOSCOPY | <input type="checkbox"/> NECK <input type="checkbox"/> BACK |
| <input type="checkbox"/> WRIST (L / R) | <input type="checkbox"/> CARPAL TUNNEL (L / R) | <input type="checkbox"/> ELBOW (L / R) | <input type="checkbox"/> ANKLE (L / R) | <input type="checkbox"/> FOOT (L / R) |
| <input type="checkbox"/> BUNION (L / R) | <input type="checkbox"/> SHOULDER SCOPE (L / R) | <input type="checkbox"/> ROTATOR CUFF (L / R) | <input type="checkbox"/> KNEE SCOPE (L / R) | <input type="checkbox"/> ACL (L / R) |
| <input type="checkbox"/> KNEE REPLACEMENT (L / R) | <input type="checkbox"/> HIP REPLACEMENT (L / R) | <input type="checkbox"/> PLASTIC SURGERY | <input type="checkbox"/> FRACTURE SURGERY | <input type="checkbox"/> CANCER SURGERY |
| <input type="checkbox"/> OTHER: _____ | PLEASE EXPLAIN AND GIVE DATES OF PROCEDURES: _____ | | | |

ANY PROBLEMS WITH ANESTHESIA? No Yes Describe: _____
HAVE YOU HAD ANY ANESTHESIA OR ANY SURGERY WITHIN THE PAST 6 MONTHS. No Yes If so, when: _____

MEDICATIONS: List any medications, herbal supplements, or vitamins you are currently taking, or have taken within the last 45 days.
Include the dose & reason for the medication. **NOT TAKING ANY MEDICATION**

ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES. If yes, please list and what happens? _____
ARE YOU ALLERGIC TO EGGS, SHELLFISH, IODINE, OR OTHER FOODS? NO YES If yes, please list. _____

SOCIAL HISTORY:

Do you smoke? No Yes Cigarettes Cigars Pipes Chewing tobacco **Do you use drugs?** No Yes
 How much? How Often? How many years? _____ Quit smoking When?: _____
Do you drink alcohol? No Yes Socially How much? _____ How Often? _____ Quit drinking When?: _____

For Students: What school do you attend? _____ What grade are you in? _____
For Athletes: What position do you play? _____

Do you exercise? NEVER RARELY OCCASIONALLY MONTHLY WEEKLY DAILY

ACTIVITIES: JOGGING WALKING GOLF TENNIS SWIMMING SURFING BIKING AEROBICS
 WEIGHTS SKIING BASEBALL FOOTBALL BASKETBALL SOCCER OTHER: _____

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FAMILY HISTORY:

Mother: Age _____ Living Healthy Illness _____ Deceased / Cause of Death _____
Father: Age _____ Living Healthy Illness _____ Deceased / Cause of Death _____
Brothers: Age _____ Living Healthy Illness _____ Deceased / Cause of Death _____
Sisters: Age _____ Living Healthy Illness _____ Deceased / Cause of Death _____
Children: Age _____ Living Healthy Illness _____ Deceased / Cause of Death _____
Adopted: Yes No If yes, at what age? _____ Do you know your biological family history? Yes No

REVIEW OF SYSTEMS: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS? None apply

| | | |
|--|---|--|
| General <input type="checkbox"/> No <input type="checkbox"/> Yes Unintended weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes Loss of appetite <input type="checkbox"/> No <input type="checkbox"/> Yes Weakness <input type="checkbox"/> No <input type="checkbox"/> Yes Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes Fevers <input type="checkbox"/> No <input type="checkbox"/> Yes Chills <input type="checkbox"/> No <input type="checkbox"/> Yes Night sweats | Pulmonary <input type="checkbox"/> No <input type="checkbox"/> Yes Shortness of breath <input type="checkbox"/> No <input type="checkbox"/> Yes Coughing <input type="checkbox"/> No <input type="checkbox"/> Yes Wheezing <input type="checkbox"/> No <input type="checkbox"/> Yes Coughing up blood Gastrointestinal <input type="checkbox"/> No <input type="checkbox"/> Yes Indigestion <input type="checkbox"/> No <input type="checkbox"/> Yes Gas <input type="checkbox"/> No <input type="checkbox"/> Yes Nausea <input type="checkbox"/> No <input type="checkbox"/> Yes Vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes Yellow skin <input type="checkbox"/> No <input type="checkbox"/> Yes Abdominal pain <input type="checkbox"/> No <input type="checkbox"/> Yes Constipation <input type="checkbox"/> No <input type="checkbox"/> Yes Diarrhea <input type="checkbox"/> No <input type="checkbox"/> Yes Black stools <input type="checkbox"/> No <input type="checkbox"/> Yes Rectal bleeding | Psychiatric <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes Depression <input type="checkbox"/> No <input type="checkbox"/> Yes Insomnia <input type="checkbox"/> No <input type="checkbox"/> Yes Nervousness <input type="checkbox"/> No <input type="checkbox"/> Yes Confusion <input type="checkbox"/> No <input type="checkbox"/> Yes Memory loss <input type="checkbox"/> No <input type="checkbox"/> Yes Other _____ |
| Skin <input type="checkbox"/> No <input type="checkbox"/> Yes Rash <input type="checkbox"/> No <input type="checkbox"/> Yes Hives <input type="checkbox"/> No <input type="checkbox"/> Yes Lesions <input type="checkbox"/> No <input type="checkbox"/> Yes Scars <input type="checkbox"/> No <input type="checkbox"/> Yes Varicose veins <input type="checkbox"/> No <input type="checkbox"/> Yes Change in hair or nails <input type="checkbox"/> No <input type="checkbox"/> Yes Breast mass(es) | Genitourinary <input type="checkbox"/> No <input type="checkbox"/> Yes Frequent urination <input type="checkbox"/> No <input type="checkbox"/> Yes Urgent urination <input type="checkbox"/> No <input type="checkbox"/> Yes Painful urination <input type="checkbox"/> No <input type="checkbox"/> Yes Awaken to urinate <input type="checkbox"/> No <input type="checkbox"/> Yes Incontinence <input type="checkbox"/> No <input type="checkbox"/> Yes Kidney stones <input type="checkbox"/> No <input type="checkbox"/> Yes Penile/vaginal discharge <input type="checkbox"/> No <input type="checkbox"/> Yes Blood in urine <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility | Endocrine <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive urination <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive thirst <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive appetite <input type="checkbox"/> No <input type="checkbox"/> Yes Heat intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes Cold intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes Goiter |
| HEENT <input type="checkbox"/> No <input type="checkbox"/> Yes Blurred vision <input type="checkbox"/> No <input type="checkbox"/> Yes Double vision <input type="checkbox"/> No <input type="checkbox"/> Yes Eye pain <input type="checkbox"/> No <input type="checkbox"/> Yes Ear pain <input type="checkbox"/> No <input type="checkbox"/> Yes Deafness <input type="checkbox"/> No <input type="checkbox"/> Yes Nosebleed <input type="checkbox"/> No <input type="checkbox"/> Yes Nasal discharge <input type="checkbox"/> No <input type="checkbox"/> Yes Dentures <input type="checkbox"/> No <input type="checkbox"/> Yes Sore throat / Hoarseness <input type="checkbox"/> No <input type="checkbox"/> Yes Difficulty swallowing | Hematologic / Lymphatic <input type="checkbox"/> No <input type="checkbox"/> Yes Lymph node swelling <input type="checkbox"/> No <input type="checkbox"/> Yes Lymph node tenderness <input type="checkbox"/> No <input type="checkbox"/> Yes Abnormal bleeding <input type="checkbox"/> No <input type="checkbox"/> Yes Slow to heal after cuts <input type="checkbox"/> No <input type="checkbox"/> Yes Anemia | Musculoskeletal <input type="checkbox"/> No <input type="checkbox"/> Yes Joint pain/stiffness <input type="checkbox"/> No <input type="checkbox"/> Yes Joint swelling <input type="checkbox"/> No <input type="checkbox"/> Yes Joint deformity <input type="checkbox"/> No <input type="checkbox"/> Yes Muscle pain/cramps <input type="checkbox"/> No <input type="checkbox"/> Yes Muscle weakness <input type="checkbox"/> No <input type="checkbox"/> Yes Cold extremities |
| Cardiovascular <input type="checkbox"/> No <input type="checkbox"/> Yes Chest pain (Angina) <input type="checkbox"/> No <input type="checkbox"/> Yes Palpitations <input type="checkbox"/> No <input type="checkbox"/> Yes Irregular heartbeat <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatic fever <input type="checkbox"/> No <input type="checkbox"/> Yes Ankle swelling | | Neurological <input type="checkbox"/> No <input type="checkbox"/> Yes Loss of consciousness <input type="checkbox"/> No <input type="checkbox"/> Yes Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes Dizziness <input type="checkbox"/> No <input type="checkbox"/> Yes Seizures/Convulsions <input type="checkbox"/> No <input type="checkbox"/> Yes Fainting spells |

Females: Are you pregnant? No Yes
What was the first day of your last menstrual period? _____

PLEASE CHECK THAT YOU HAVE COMPLETELY FILLED OUT AND SIGNED ALL FORMS PRIOR TO SEEING THE DOCTOR.

Patient Signature: _____



SIGN HERE

Date: _____

I certify that the information provided above is correct and true.

Reviewed By: _____

Michael R. Mann, M.D.

Date: _____

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Patient Name: _____
Last First Middle

Date of Birth: _____ SSN: _____ SEX: _____

(Please Circle) Martial Status: S/ M/ D/ W EMAIL: _____

Home Address City State Zip

Home Phone: _____ Work: _____ Cell: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Who referred you? (doctor, friend, insurance, internet search, or yellow pages)

Referred by: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

****IF PATIENT IS MINOR OR IF SOMEONE OTHER THAN THE PATINET IS THE
GUARANTOR/INSURED PLEASE COMPLETE THE SECTION BELOW!!!**

Guarantor/Insured Name: _____ SS# _____

Relationship: _____ DOB: _____ Phone: _____

I, _____, certify that I (or my dependent) have insurance coverage with _____ I consent and assign directly to Mann Orthopaedics, all insurance benefits for services there, as well as any rights to challenge any payment decision by my insurer(s), if any, otherwise payable to me for service rendered. This signature will authorize Mann Orthopaedics to provide the indicated Medical/Surgical care necessary for my treat. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctors to all insurance submission. Mann Orthopaedics shall be paid in full for all billed charges within seven days of any settlement pertaining to personal injury and lawsuits applicable to services rendered. In addition, my insurance company will be notified of the settlement and reimbursed monies previously paid to Mann Orthopaedics upon my behalf for services rendered. I certify that the above information is correct to the best of my knowledge. I will not hold my physician or any other member or his/her staff responsible for any errors or omission that I may have made upon the completion of this form.

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintain health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- * A basis for planning for my care and treatment
- * A means of communication among the many healthcare professionals who contribute to my care
- * A source of information for applying my diagnosis and surgical information to my bill
- * A means by which a third-party payer can certify that services were actually provided
- * A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals

I understand and have seen a Notice of Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the prior to signing this consent. I understand the organization reserves the right to change their notice and practices, and prior to implementation will post a copy of a revised notice in the office. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to accept them to the extent that the organization has already taken action to reliance thereon.

**SIGN HERE**

Signature of Patient/ if patient is a minor Signature of Guarantor

Date

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The following information is provided to avoid misunderstanding regarding payment for services and to provide full disclosure.

- Prompt payment allows us to control cost. Outstanding accounts cost both time and money; therefore, all patients will be required to establish financial arrangements for payment of their account.
- All deductibles, co-pays, co-insurance, and non-covered service amounts are the patient's responsibility. It is the patient's responsibility to obtain their own referral if needed by Insurance Carrier. **Mann Orthopaedics out sources all billing to a third party and they will file to your insurance all reimbursable services to both your primary and secondary insurance carrier.**
- Each month you will receive a monthly statement from the third party company for outstanding services for an additional fee for the sum no more than one dollar. This monthly statement is due and payable within 30 days. If your payment is late, then a reminder notice will be mailed indicating there is a problem with your account. It is your responsibility to notify the billing office of any financial special arrangements needed. Interest and late charges will be assessed.
- By law, all patient balances are subject to late fees and/or interest charges past thirty days. Insufficient funds are subject to a fee charge in addition to late fees. All new patients will be required to remit full payment to establish an account.
- Depending upon your individual insurance plan, any service(s) not covered and provided will be the full financial responsibility of the patient or guarantor.
- It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by you claim and insure your carrier remits payment. If a problem occurs with you claim you will be required to establish written financial agreements with our practice until your insurance problem is resolved. You will be responsible for late charges due to delayed payment when your insurance company is seeking additional information from the patient.
- We reserve the right to check your credit prior, during, or after service it provided.
- Medical records and films are owned by the practice and are required by law to archive for seven years to ten years.
- You may purchase a copy of these records for the sum of twenty-five dollars for the first 20 pages and fifty cents for each additional page and twenty-five dollars for copies of X-rays per AMA guidelines.
- Durable Medical Equipment or DME are not returnable or refundable. OSHA requirements prohibit the reselling of certain DME's. Full payment for DME is required at the time of service.
- Paperwork requested for the physician to complete and sign is a minimum charge of fifty dollars and FMLA papers are fifty dollars due at the time of request.
- Telephone consultations with the physician are often considered an "office visit" and will be billed as such, depending upon the nature of the call.
- All prescription refill requests are subject to a twenty four hour time notification. Request for weekend and holiday refills will be during normal business hours.
- All patients refusing to remit payment after sixty days without pending insurance or prior financial arrangements will force us to limit future credit until the previous balance is paid in full or written financial agreements are accomplished. All patients will be required to sign a legal written agreement with Mann Orthopaedics to alleviate any current delinquency. Please notify us immediately if any errors appear on the statement.
- These disclosures are subject to change without notice.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and open communication. The staff is instructed to make every effort available to you to clarify any misunderstanding you have concerning your balance. We hope to avoid disagreements regarding payment for professional services. If you have any questions concerning our policy and need assistance, please contact us.

Signature of Guarantor

Date

Signature of Witness

Date

SIGN HERE

WITNESS