



**Drake S. Borer, M.D. • David C. Lavery, M.D. • Earl J. Kilbride, M.D.**  
**1313 Red River Suite# 200 Austin, TX 78701**  
**512-391-1751 • Fax: 512-391-1906**

Dear Patient,

In an effort to minimize office wait time, please fill out the enclosed forms, **sign them** and submit them to our office prior to your appointment. We are located in the Brackenridge Professional building on the 2<sup>nd</sup> floor. Our office is connected to Brackenridge Hospital and the Brackenridge Hospital parking garage.

**If you have hired an attorney, or have questions about legal resources regarding the circumstances pertaining to your injury please contact our office or Physicians Professional Billing as soon as possible.**

**Patients with Insurance:**

Please be advised that our doctors may not be contracted with your insurance plan. If we are not contracted (Out of Network) with your insurance you will be responsible for all remaining balances after your insurance has paid. This may include: Deductibles, co-insurances, over usual and customary charges, etc.

If you are enrolled in an HMO plan (Health Maintenance Organization) or a POS plan (Point of Service), you must inform your primary care physician that you have scheduled an appointment with us.

You may be required to provide us with a referral from your physician and **you** are responsible for obtaining referrals for follow-up appointments in our office. Please request your referral at least seven days in advance so your physician can prepare and deliver this document.

If you have any questions regarding your insurance coverage, you must call the number listed on your insurance card. For all billing questions call 877-937-7240.

**PLEASE KEEP THIS COPY FOR YOUR RECORDS**

**Drake S. Borer, M.D. • David C. Lavery, M.D. • Earl J. Kilbride, M.D.**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_  Male

Spouse's name \_\_\_\_\_ Date of birth \_\_\_\_\_  Female

**Who referred you to our office?**

Post Op Visit  Hospital \_\_\_\_\_  Doctor \_\_\_\_\_  School \_\_\_\_\_

**What is the reason for your visit today?** \_\_\_\_\_

**How long have you had these symptoms?** \_\_\_\_\_

**Have you seen any other physician for this complaint?** ( ) Yes ( ) No

Dr. \_\_\_\_\_ when/where \_\_\_\_\_

**Have you ever had problems with this part of your body before?** ( ) Yes ( ) No

Nature of the problem \_\_\_\_\_ when \_\_\_\_\_ Surgery ( ) Yes ( ) No

Type of surgery \_\_\_\_\_ when/where \_\_\_\_\_

**Have you missed time from work because of your complaint?** If so, please state when you were first *unable* to work and the date you *returned* to work (if applicable): \_\_\_\_\_

**Please list significant medical history** (diabetes, high blood pressure, etc.) \_\_\_\_\_

**Are you currently taking any medications?** Please list the names of the medicines: \_\_\_\_\_

**Please list any allergies to drugs or anesthesia:** \_\_\_\_\_

Are you  right or  left hand dominant?

Have you had a bone density study done? ( ) Yes ( ) No If so, when/where \_\_\_\_\_

**Employer's name, address & phone:** \_\_\_\_\_

\_\_\_\_\_ Job title \_\_\_\_\_

Description \_\_\_\_\_

**Spouse's Employer's name, address & phone:** \_\_\_\_\_

**Is your complaint the result of an accident or injury?**  Yes  No

**IF YES, PLEASE COMPLETE FOLLOWING SHEET**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## ACCIDENT DETAILS

1. Describe how your injury occurred \_\_\_\_\_  
\_\_\_\_\_

Location of the accident \_\_\_\_\_

Date of the accident \_\_\_\_\_

2. Was this injury work related? Yes ( ) No ( )

If Yes, your employer's name \_\_\_\_\_ Phone# \_\_\_\_\_

If Yes, did you report injury to your employer? Yes ( ) No ( )

If self employed, do you carry an accident policy? Yes ( ) No ( )

3. Was this an automobile accident? Yes ( ) No ( )

I was: the driver ( ) a passenger ( ) a pedestrian ( )

My auto insurance company is: \_\_\_\_\_

Insurance company phone # \_\_\_\_\_ Adjustor's name \_\_\_\_\_

Claim or Policy #: \_\_\_\_\_

This is the information on the other drivers: (if known)

Name \_\_\_\_\_ 2. Name \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Ins. Co. \_\_\_\_\_ Ins.Co. \_\_\_\_\_

Claim # \_\_\_\_\_ Claim # \_\_\_\_\_

4. If you were NOT in an auto accident, complete this section

Did your injury occur on someone else's property? Yes ( ) No ( )

Name and telephone # of property owner \_\_\_\_\_

Adjustor Name \_\_\_\_\_ Phone # \_\_\_\_\_

Claim # \_\_\_\_\_

5. Have you received any settlement money or insurance money because of your injury? Y ( ) N ( )

If Yes, Amount Paid \$ \_\_\_\_\_ Who Paid \_\_\_\_\_

6. Do you intend to make any claims other than Health Insurance? Y ( ) N ( )

Have you hired an attorney because of the accident? Y ( ) N ( )

Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_

Attorney Address \_\_\_\_\_

7. If none of the above apply, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The foregoing is true and correct to the best of my knowledge.**

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Print Name Parent or Guardian (for minor)



## **GLOBAL FEES (PLEASE KEEP THIS COPY FOR YOUR RECORDS)**

Austin Skeletal Trauma Specialists follows the prescribed billing procedures which are governed, throughout the health care industry, by Physicians' Current Procedural Terminology (CPT).

For many years, CPT has dictated that surgery fees be "global," or include routine post-operative follow-up care. In 1991, CPT expanded the procedures that should be billed globally to include care of fractures, repair of lacerations, simple office surgical procedures, etc.

When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, etc., that fee not only includes the service on the day it is performed, but includes routine follow-up care, as well. The global period ranges from 30-90 days depending on the procedure. X-rays and supplies (such as casting or dressing materials, splints, braces, etc.) are not included in the "global" fee and a charge will be made for these items. **All other services related to complications or other conditions are not included in the global fee.**

### **PLEASE NOTE:**

**Some insurance plans apply a deductible to these in-office procedures since they are considered to be outpatient procedures. Please refer to your insurance policy for more information.**



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

Account#: \_\_\_\_\_

### Our Financial Policy

At Austin Skeletal Trauma Specialists we are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time services are rendered in our office. Please note that we are a private entity not affiliated with Brackenridge Hospital.

2. Keep in mind that your insurance contract is a contract between you and your insurance company. As a service to you, we will file your claims to the insurance company if you assign the benefits to the doctor- in other words, if you agree to have your insurance company pay the doctor directly. If the insurance pays a portion of your bill for services rendered while you were in the hospital, or for follow-up visits, you will be responsible for the remaining balance within 30 days.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be “non-covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

3. Please make sure that you bring your insurance card at every appointment. It is your duty to inform us of any changes that are pertinent to your account. Since we are not part of the hospital system, we do not receive updates on patient information as they are given to Brackenridge Hospital. You must call our office (512-391-1751), or let the front desk know of any changes at check-in. Failure to do so could result in a denial of payment by your insurance, or ASTS not being able to contact you in regards to your account. As a courtesy to the doctors and staff, please keep us informed. We are here to help you!

4. Please be advised that you are responsible for all payments due to us. If, for example, your injuries are covered by a personal injury policy, you, not your lawyer, personal injury policy company, or any other party is responsible for payment to us. By signature below you give us the right to take assignment of these proceeds, directly, at our choosing.

**If you have any further questions regarding your bill, please contact Physicians Professional Billing, at 877-937-7240.**

\_\_\_\_\_  
Signature of Patient/ Signature of responsible party (IF PATIENT IS UNDER 18)

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

Print Name

**Notice of Privacy Practices  
(PLEASE KEEP THIS COPY FOR YOUR RECORDS)**

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

**Uses and Disclosures**

**Treatment, Payment, Health Care Operations**

**Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. For example, we may request that your primary care physician share your medical information with us and we may share information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any, and/or assist us in obtaining insurance referrals as may be required by your health plan. Your care may also require the involvement of other specialists, for example, a pain management physician or plastic surgeon. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

**Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, submitting a claim form to your insurer in order to obtain payment for services provided to you. The form will contain medical information, such as a description of the medical service provided, that your insurer requires approving payment to us. It may also be necessary to provide clinical documentation to your insurer for payment, for example, clinic office notes, operative or procedure notes and diagnostic studies.

**Health Care Operations**

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this organization and ensure that quality care is delivered.

**Business Associates**

Austin Skeletal Trauma Specialists may disclose your medical information to third party business associates to perform certain activities of treatment, payment and operations on our behalf. We have written contracts with these associates that protect the privacy of medical information as required by HIPAA.

**Disclosures That Can Be Made Without Your Authorization**

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object.

**Public Health, Abuse or Neglect, and Health Oversight**

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products or medical devices, or to notify you in the event of a recall of any product or device.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

### **Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Is released to locate a fugitive, missing person, or suspect.
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is released because of a crime that has occurred on these premises; or
- We believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

### **Workers' Compensation**

We may disclose your medical information as required by state or federal law regarding a work-related injury.

### **Inmates**

If you are an inmate, or you are under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

### **Military, National Security and Intelligence Activities, Protection of the President**

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

### **Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors**

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

### **Disclosures Requiring an Opportunity to Agree or Object**

We honor the important role that families, friends and other loved ones play in supporting our patient's health care and treatment. At the same time, we are committed to protecting our patient's privacy as well as complying with both state and federal law. Accordingly, disclosures to other people, even family, must remain a decision that rests with the patient.

If you bring a family member or other person to an appointment with you in our office, they will be exposed to your personal health information. It is our practice to allow these individuals to accompany you to your appointment unless you otherwise object. Should you wish to visit the doctor alone, your visitor will be asked to wait in the lobby.

If you would like us to share your medical information with a member of your family, either by copies of your medical records or verbally, we will require a written authorization to do so. You may revoke this authorization at any time in writing.

### **Other Uses and Disclosures**

Other uses and disclosures will be made only with your written authorization. You may revoke this authorization at any time in writing.

### **Certain Uses and Disclosures**

#### **Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits**

It is our common practice to provide appointment reminders via telephone. We may leave a message on a home answering machine, business or mobile voice mail or leave a message with an individual answering your home telephone to remind you of your appointment. It is our standard procedure to send appointment reminder postcards for missed appointments. We may also mail information to you about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request that we modify the above procedures for you. These requests should be made in writing to the contact person listed below. We will make our best effort to accommodate your request.

### **Your Rights under Federal Privacy Regulations**

The HIPAA regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their rights.

### **Requested Restrictions**

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We may not be able to agree to this restriction in all cases.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and contact person listed below.

### **Receiving Confidential Communications by Alternative Means**

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the contact person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

### **Inspection and Copies of Protected Health Information**

You may inspect and/or copy health information that is within your medical records. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the contact person listed below.

You may not be entitled to review and access portions of the record including:

- Psychotherapy notes contained in our records may not be reviewed or copied.
- Information compiled in anticipation, or for use in, a civil, criminal or administrative action or proceeding.
- Portions of the record are denied access under other federal or state law.
- The records involve medical research.
- The records were obtained from someone other than a healthcare provider under a promise of confidentiality, and access would likely reveal the source of the information.

We can also refuse to provide access to or copies of some information if the physician has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or other person. In this event, you will have an opportunity to request a review of our decision by another licensed health care provider who was not involved in the prior decision to deny access. We will then provide or deny access in accordance with the determination of the reviewing provider.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records. If a summary or explanation of the medical record is desired, there will be a charge for preparation of the narrative.

Texas law requires that we provide copies or a narrative within 15 days of your request and payment. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

### **Amendment of Medical Information**

You may request an amendment of information in your medical record. Any such request must be made in writing to the contact person listed below. For your convenience, we have created a form with all of the pertinent information needed to evaluate your request for amendment. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Was created outside this practice
- Pertains to information that is not part of our medical record.
- Is not available for inspection because of an appropriate denial as described above.
- If the information is accurate and complete.

If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and provide you with a copy of the amended record.

If that particular record was disclosed to another party we will provide that party with a copy of the amended record. Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record.

### **Accounting of Certain Disclosures**

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are *other than* for treatment, payment, health care operations, circumstances required by state or federal law or made via an authorization signed by you or your personal representative. Please submit any request for an accounting to the contact person listed below.

### **Right to a Copy of Privacy Notice**

You have the right to receive a copy of this notice upon your request. Copies of the notice are available at the front desk.

### **Austin Skeletal Trauma Specialists' Duties**

### **Our Promise to You**

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

### **Complaints**

If you are concerned that your privacy rights have been violated, you may contact the contact person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

Region VI, Office for Civil Rights  
U.S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, TX 75202

### **Contact Person for Questions and Requests**

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Austin Skeletal Trauma Specialists  
Debbie Zuniga  
1313 Red River, Suite 200  
Austin, TX 78701  
Phone: 512-391-1751  
Fax: 512-391-1906



Account#: \_\_\_\_\_

**Acknowledgement of  
Notice of Privacy Practices**

I have been given the opportunity to review and/or receive a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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

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

Relationship to Patient: \_\_\_\_\_