PLEASE PRINT **PATIENT INFORMATION** (The Person Seeing the Physician)

PATIENT'S NAME - Last, First, Middle Initial	Email Address	Age	Birthdate / /

ADDRESS - Number and Street	City	State	Zip

Sex: ❒ Male ❒ Female	Marital Status: ❒ M - Married ❒ S - Single ❒ D - Divorced ❒ W - Widow/Widower	Spouse's Name	Patient's Driver's License No.

Occupation or Student	Patient's Social Security No.	Home Phone (include area code) ( )	Business Phone (include area code) ( )

Employer Name	Employer Address	City	State	Zip

IMPORTANT → **DO YOU HAVE ANY ALLERGIES?** ❒ NOT KNOWN ❒ NO ❒ YES What Kind?

Patient's Personal Physician or Primary Care Physician (PCP)	Referring Physician	Referred By

❒ ***Same as above*** **RESPONSIBLE PARTY INFORMATION** (The Person Who Is Financially Responsible)

RESPONSIBLE PARTY NAME - Last, First, Middle Initial		Address - Number and Street	
City	State	Zip	Home Phone (include area code) ( )
Resp. Party Social Security No.	Driver's License No.	Employer	Business Phone (include area code) ( )

EMERGENCY CONTACT

NAME - Last, First, Middle Initial	Relationship	Address - Number and Street	
City	State	Zip	Home Phone (include area code) ( )

INSURANCE INFORMATION (Please Present Insurance Card to Receptionist)

Do **NOT** indicate your Worker's Compensation Insurance Carrier here. This must be verified by your employer prior to seeing the Physician.

Type: ❒ Medicare ❒ Insurance Plan:	Subscriber's Name (The person who has the policy)	Subcriber's Social Security No.
Insurance Company Name	Insurance Co. Phone No. (include area code)	SUBSCRIBER DATE OF BIRTH
Insurance Company Address	Policy No.	Group No.
Employer, If Group Coverage		
Patient's Relationship to Subscriber: ❒ S - Self ❒ W - Wife ❒ H - Husband ❒ C - Child ❒ O - Other	METHOD OF PAYMENT: ❒ CASH ❒ CHECK ❒ DEBIT CARD ❒ CREDIT CARD	

Please read before signing - **Assignment of Benefits, Medical Release, and Statement of Financial Responsibility**

I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A. to release medical information and/or records that may be necessary to request reimbursement from (including but not limited to): insurance companies, HMO's, PPO's, Managed Care Contracting agencies, contracted Independent Physician Associations (IPA's), Texas Department of Insurance Division of Workers Compensation, if injury is work related, Third Party Review organizations contracted by an insurance company to review insurance claims, and/or insurance adjusters, to whom a claim has been submitted. I also give my authorization to have medical records mailed, delivered or FAXed to my Primary Care Physician (PCP), "Gatekeeper" or any other physician responsible for my medical care under a managed care contract (if applicable). I also give my authorization to have my medical record mailed, delivered or FAXed to a consulting physician who may review my medical treatment plan with my Plano Orthopedic Physician. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician's Professional Associations of: Drs. Sutker, Barber, Smith, Lund, Troop, Courtney, Crates, Dauber, Carmody, Chaim, Montgomery et al. In the event that I receive a payment from my insurance carrier where my physician has filed the claim on my behalf, I will forward that payment to my physician to have it applied to my account. I understand that an insurance claim will be filed with my primary insurance carrier only (Plano Orthopedic will not file on "Secondary" insurance). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges (for non-work related injuries) whether or not paid by said insurance (less any mandated or contractual adjustments). I understand and agree that I am responsible for responding promptly to my insurance company if they request any additional information or accident report and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred. I understand that any overpayment on my account will be promptly refunded. If an account is established, I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A., to obtain a credit report when necessary in regards to my account. Payments by insurance plans on my account must be made within 60 days of filing, and any co-pay or deductible amounts remaining are due by the responsible party and must be paid in full within 30 days after insurance has paid, or there may be a late fee assessed against my account of 1.5% each month on the unpaid balance. I understand that this form must be updated at least annually, may be updated at each visit, and that I will provide Plano Orthopedic with any changes of address or insurance coverage immediately. Failure to notify Plano Orthopedic of any insurance plan changes, could result in loss of insurance benefits and could make me liable for medical charges. Proof of identity is required (e.g., drivers license) for each patient and/or responsible party. I understand that I need to present my insurance card at each visit, and understand that I may be required by my insurance plan to pay my co-payment at each visit. My email address will be used to notify me of appointments or other medical related issues and will not be sold or delivered to any other entity.

SIGNATURE OF RESPONSIBLE PARTY ______________________ **DATE** __________

SIGNED BY ______________________ (NAME PRINTED) **RELATIONSHIP TO PATIENT IF MINOR:** ❒ PARENT ❒ GUARDIAN

Plano Orthopedic Sports Medicine & Spine Center, P.A.

Universal Injury, Condition and/or Accident Statement

Patient Name ___________________________________ Today's Date ____/____/____
Full Name

Please complete the following statement. Most Insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury or condition and sign In BOX 4. We must have Box 1 "Date of Injury or Condition" completed to file your claim.

1

Date of Injury or Condition: ____________________________ < (COMPLETE DATE ON OR ABOUT)
Month / Day / Year THIS DATE IS REQUIRED FOR INSURANCE FILING

→ ***The following details are required IF this was an INJURY***:

Where did injury occur: ____
(e.g., Auto, home, parking lot, friend's house, etc.; if at work, complete Box 2)

How did injury occur (brief summary): ____

____

2

Was injury or condition work related? [ ] YES [ ] NO < (Required/Please Answer)
If YES then…

Name of Employer: ____
Phone

Employer contact or Supervisor: ____
Phone

Adjuster's Name (if known): ____
Phone

3

Is there a possible third party liability statement (e.g. Auto, Homeowners, Property): [ ] YES [ ] NO
If YES then…

Name of Employer: ____
Phone

Adjuster's Name (if known): ____
Phone

4

I certify that this information is 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 medical charges incurred.

____________________________________ Date: ____________________
Patient's Signature (or Responsible party if patient is a minor)

Plano Orthopedics & Sports Medicine Center

Notice of Privacy Practices

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.

Plano Orthopedics & Sports Medicine Center has adopted the following privacy policies.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Plano Orthopedics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government-mandated reporting.

Publice Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public heath department.

Other uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

SIGNATURE NEEDED ON THIRD PAGE

Individual Rights
You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your PHI.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your PHI.
4. The right to amend or submit corrections to your PHI.
5. The right of receive an accounting of how and to whom your PHI has been disclosed.
6. The right to receive a printed copy of this notice.

Plano Orthopedics Duties
We are required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you do so by sending a letter outlining your concerns.

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed, and give my permission to Plano Orthopedics & Sports Medicine Center to use and disclose my health information in accordance with it.

______________________________	______________________________
Name of Patient	Signature of Patient
______________________________	______________________________
Date	Signature of Parent or Guardian

If you would like to indicate a child or spouse to *Discuss* medical information with our Doctors or Physician Assistant please indicate below.

______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship
______________________________	______________________________
Name	Relationship

This is not release of MEDICAL RECORDS.

There is a separate form you will need to fill out. Please ask for one if you would like to release your PHI to any other doctor or facility. You will be asked to fill one out if you request your records. The form is available on our website. www.posmc.com.

This authorization will expire in two (2) years from the above date unless written revocation is received.

Cameron N. Carmody, M.D.

Randy K Farrer, M.S., PA-C

Plano Orthopedic Sports Medicine and Spine Center

This form is concerned with your current spinal condition. Please complete the questions carefully. We understand that this takes extra time, however, your accurate responses will give us a better understanding of problem, aid us in accurate diagnosis and help provide appropriate treatment. If possible, you need to obtain all prior spine x-rays and diagnostic tests as well as their reports. Please bring these with you on the day of your appointment. It is also important to note that Dr Carmody does not prescribe long term pain medications.

Patient Name:___________________ Referred by:_____________

Age:________Male/Female_______ Date___________________

New Patient or New Injury Information Form

What is the reason for your visit today?

When did you first notice a problem?

What caused your pain/problem?

Have you had this problem in the past? (explain)

What makes your condition feel better?

What makes your condition feel worse?

Have you been treated for this condition already?
If yes, fill out what applies below:

Treatment(s):

☐ **Doctor** ____
Name **Number**

☐ **Physical Therapy (list dates)**_________________________________

☐ **Steroid injection** ____

☐ **Chiropractor treatments** ___________________________________

☐ **Over the Counter Medications (list)**___________________________

☐ **Pain Medications (list)**_____________________________________

Did you bring any films to your visit today?

___X-Ray Date_______

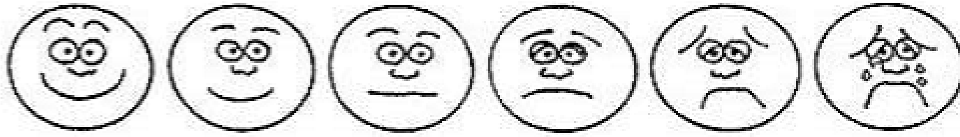
___MRI Date_______

___Other Date_______

Are you having or have you had any of the following?

_____ Trouble with bladder (urine) control _____ Trouble with bowels control

_____ Pain that wakes me from sleep _____History of Cancer



0 1 2 3 4 5 6 7 8 9 10

No pain **Unbearable pain**

Using the above scale rank any of the following that apply:

Low back pain?	0	1	2	3	4	5	6	7	8	9	10
Leg pain?	0	1	2	3	4	5	6	7	8	9	10
Neck pain?	0	1	2	3	4	5	6	7	8	9	10
Arm pain?	0	1	2	3	4	5	6	7	8	9	10

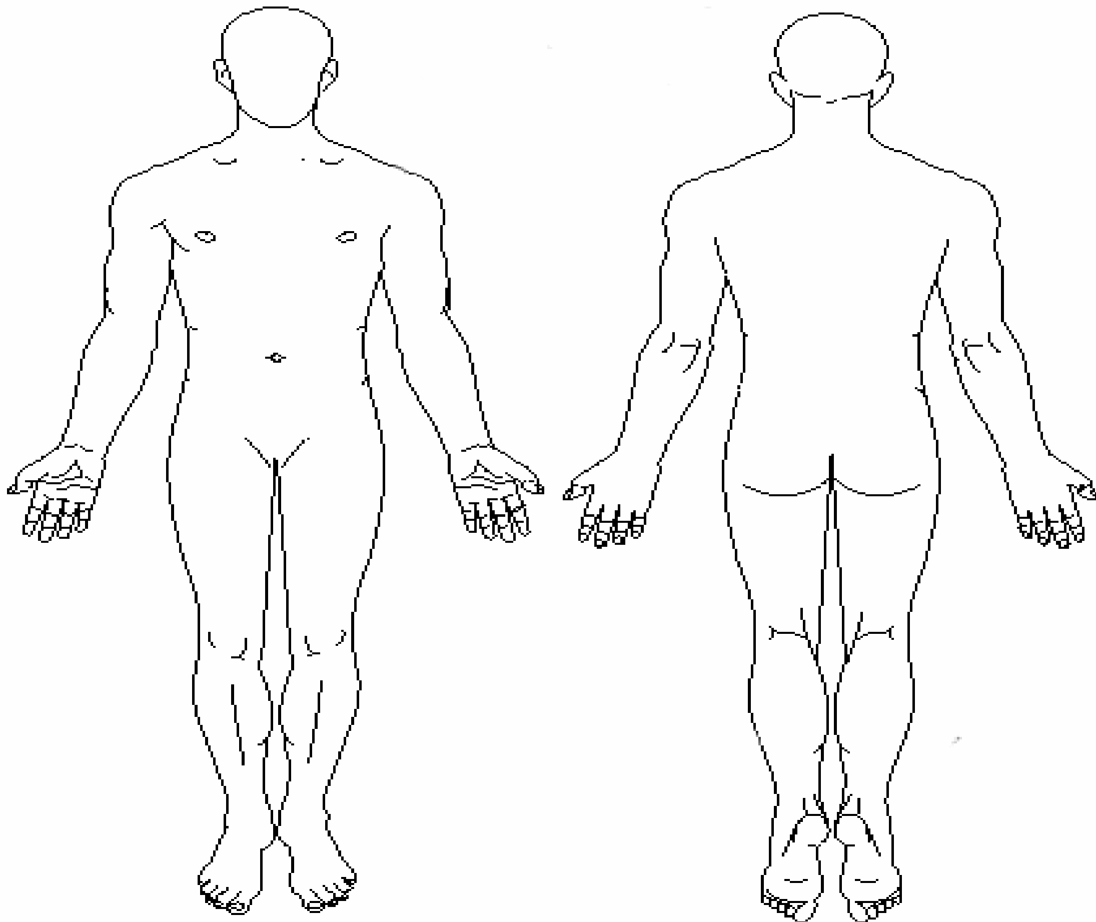
Is any other information you would like us to know about your condition?________________

____

____

On the drawing below, mark the area of your body where you feel the sensations listed.

>>>>> Sharp Pain = = = Numbness/Tingling XXX Ache



GENERAL MEDICAL HISTORY

(mark any that apply to you)

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Asthma
☐ Lung disease ☐ Seizures ☐ Blood clots ☐ Neuropathy
☐ Thyroid disease ☐ Kidney disease ☐ Cancer ☐ Drug dependency
☐ Heartburn ☐ Ulcers ☐ Mental Illness ☐ High cholesterol
☐ Anxiety ☐ Depression ☐ Vascular Disease ☐ Alcoholism
☐ Other (not listed above)____
____

SURGICAL HISTORY

Please list **all** surgeries with dates or operation.

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

ALLERGIES

☐ No known allergies; ☐ Known allergies, please list:_________________________
____

MEDICATIONS

Please list **all** medications you take:

Medication name	Dosage	When taken
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________

☐ List of medicines are provided on a separate sheet, prepared in advance of today's appointment. __________ (initial) _________ (date)

Review of Body Systems

Do you have a problem with any of the following? Mark all that apply:

Cardiovascular:
☐ Shortness of Breath
☐ Chest Pain
☐ Leg Swelling
☐ History of Heart Disease
☐ Blood Clot History

Neurological:
☐ Seizure/Tremors
☐ Stroke
☐ Headaches
☐ Paralysis

Musculoskeletal:
☐ Osteoporosis
☐ Bone Tumor(s)
☐ Stress Fractures
☐ Scoliosis

Gastrointestinal:
☐ Stomach Ulcers
☐ Jaundice
☐ Blood in Stool
☐ Weight gain/loss

Respiratory:
☐ Asthma
☐ Chronic Cough
☐ Pneumonia
☐ Pain with breathing

Genitourinary:
☐ Inability to urinate
☐ Incontinence
☐ Painful urination
☐ Bloody Urination

FAMILY MEDICAL HISTORY

Please fill in any medical issues that apply to the listed family member

	Age	Living/Deceased?	Medical problems(List Known medical conditions)
Father:	___	____________	____
Mother:	___	____________	____
Brother(s)	___	____________	____
Sister(s)	___	____________	____

Is there any other family history you feel is pertinent to your condition: ______________________

____

SOCIAL HISTORY

Occupation: ________________________________. Are you currently working? _____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/widower

Number of children _____. Still living at home____.

Highest education attained: High School, Some College, College Degree, Advanced Education

Servings of alcoholic beverages per week ______.

Tobacco use? Yes/No Pack per day ______. Years smoked: _______. Chewing tobacco Y/N

☐ Primary Care Doctor:____

Name Phone Number

☐ Cardiologist: ____

Name Phone Number

☐ Pain Management Doctor:____

Name Phone Number

Were you referred by a Physician? Yes No

Would you like a copy of your visit notes sent to this referring Physician? Yes No

Physician's name:________________________________ Number______________________

Patient Signature:______________________________ Date __________________________

Please Sign acknowledging that you have filled out this form to the best of your knowledge.

Reviewed by___________Date__________

Oswestry Quality of Life Questionnaire Lumbar Spine

Patient Name______________________ Date________________

Please answer every question and circle only the **one** statement in each section that applies to you. While you may consider that two of the statements in any one section relate to you, please check just the **one** which most closely describes your situation.

Section 1: Pain Intensity

0- I have no pain at the moment.
1- The pain is very mild at the moment
2- The pain is moderate at the moment.
3- The pain is fairly severe at the moment.
4- The pain is very severe at the moment.
5- The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, Dressing, etc.)

0- I can look after myself normally without causing extra pain.
1- I can look after myself normally but it is very painful.
2- It is painful to look after myself and I am slow and careful.
3- I need some help but manage most of my personal care.
4- I need help everyday in most aspects of self care.
5- I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

0- I can lift heavy weights without extra pain.
1- I can lift heavy weights but it gives extra pain.
2- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, ie- on a table
3- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned, ie- on a table.
4- I can lift only very light weights.
5- I cannot lift or carry anything at all.

Section 4: Walking

0- Pain does not prevent me walking any distance.
1- Pain prevents me walking more than a mile.
2- Pain prevents me walking more than a quarter mile.
3- Pain prevents me walking more than 100 yards.
4- I can only walk using a cane or crutches.
5- I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

0- I can sit in any chair as long as I like.
1- I can sit in my favorite chair as long as I like.
2- Pain prevents me from sitting for more than 1 hour.
3- Pain prevents me from sitting for more than half an hour.
4- Pain prevents me from sitting for more than 10 minutes.
5- Pain prevents me from sitting at all.

Section 6: Standing

0- I can stand as long as I want without extra pain.
1- I can stand as long as I want but it gives me extra pain.
2- Pain prevents me from standing for more than 1 hour.
3- Pain prevents me from standing for more than ½ an hour.
4- Pain prevents me from standing for more than 10 min.
5- Pain prevents me from standing at all.

Section 7: Sleeping

0- My sleep is never disturbed by pain.
1- My sleep is occasionally disturbed by pain.
2- Because of pain I have less than 6 hours sleep.
3- Because of pain I have less than 4 hours sleep.
4- Because of pain I have less than 2 hours sleep.
5- Pain prevents me from sleeping at all.

Section 8: Sex life (if applicable) ☐ **NA**

0- My sex life is normal and causes no extra pain.
1- My sex life is normal but causes some extra pain.
2- My sex life is nearly normal but is very painful.
3- My sex life is severely restricted by pain.
4- My sex life is nearly absent because of pain.
5- Pain prevents any sex life at all.

Section 9: Social Life

0- My social life is normal and causes me no extra pain.
1- My social life is normal but increases the degree of pain.
2- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
3- Pain has restricted my social life and I do not go out as often.
4- Pain has restricted social life to my home.
5- I have no social life because of pain.

Section 10: Traveling

0- I can travel anywhere without pain.
1- I can travel anywhere but it gives extra pain.
2- Pain is bad but I manage journeys over two hours.
3- Pain restricts me to journeys of less than one hour.
4- Pain restricts me to short necessary journeys under 30 minutes.
5- Pain prevents me from travelling except to receive treat.

TOTAL _________

Please sign below acknowledging that you have filled out this form to the best of your knowledge.

____(Patient or Guardian Signature) Date______________

Neck Disability Index

Patient Name______________________ Date________________

Please read: This questionnaire has been designed to give the doctor information on how your neck pain has affected your ability to manage in everyday life. Please answer every question and circle only the **one** statement in each section that applies to you.

Section 1: Pain Intensity

0- I have no pain at the moment.
1- The pain is mild at the moment.
2- The pain comes and goes and is moderate.
3- The pain is moderate and does not vary much.
4- The pain comes and goes and is severe.
5- The pain is severe and does not vary much.

Section 2: Personal Care (Washing, Dressing, etc.)

0- I can look after myself normally without causing extra pain.
1- I can look after myself normally but it causes extra pain.
2- It is painful to look after myself and I am slow and careful.
3- I need some help but manage most of my personal care.
4- I need help everyday in most aspects of self care.
5- I do not get dressed, wash with difficulty and stay in bed.

Section 3: Lifting

0- I can lift heavy weights without extra pain.
1- I can lift heavy weights but it causes extra pain.
2- Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, ie- on a table.
3- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned, ie- on a table.
4- I can lift very light weights.
5- I cannot lift or carry anything at all.

Section 4: Reading

0- I can read as much as I want to with no pain in my neck.
1- I can read as much as I want with slight pain in my neck.
2- I can read as much as I want with moderate pain in my neck.
3- I cannot read as much as I want because of moderate pain.
4- I cannot read as much as I want because of severe pain in my neck.
5- I cannot read at all.

Section 5: Headache

0- I have no headache at all.
1- I have slight headaches which come infrequently.
2- I have moderate headaches which come infrequently.
3- I have moderate headaches which come frequently.
4- I have severe headaches which come frequently.
5- I have headaches most of the time.

Section 6: Concentration

0- I can concentrate fully when I want to with no difficulty.
1- I can concentrate fully when I want to with slight difficulty.
2- I have fair degree of difficulty concentrating when I want to.
3- I have a lot of difficult in concentrating when I want to.
4- I have a great deal of difficulty concentrating when I want to.
5- I cannot concentrate at all.

Section 7: Work

0- I can do as much work as I want to.
1- I can only do my usual work, but no more.
2- I can do most of my usual work, but no more.
3- I cannot do my usual work.
4- I can hardly do any work at all.
5- I cannot do any work at all.

Section 8: Driving

0- I can drive without neck pain.
1- I can drive as long as I want with slight pain in my neck.
2- I can drive as long as I want with moderate pain in my neck.
3- I cannot drive as long as I want because of moderate pain in my neck.
4- I can hardly drive at all because of severe pain in my neck.
5- I cannot drive at all.

Section 9: Sleeping

0- I have no trouble sleeping.
1- My sleep is slightly disturbed (less than 1 hour sleepless)
2- My sleep is mildly disturbed (1-2 hours sleepless)
3- My sleep is moderately disturbed (2-3 hours sleepless)
4- My sleep is greatly disturbed (3-5 hours sleepless)
5- My sleep is completely disturbed (5-7 hours sleepless)

Section 10: Recreation

0- I am able to engage in all recreational activities with no pain in my neck.
1- I am able to engage in all recreational activities with some pain in my neck.
2- I am able to engage in most, but not all recreational activities because of pain in my neck.
3- I am able to engage in a few of my usual recreational activities because of pain in my neck.
4- I can hardly do any recreational activities because of pain in my neck.
5- I cannot do any recreational activities at all.

TOTAL ________

Please sign below acknowledging that you have filled out this form to the best of your knowledge.

____(Patient or Guardian Signature) Date______________

Plano Orthopedic
Sports Medicine & Spine Center
5228 W. Plano Parkway
Plano, TX 75093
972.250.5700

PLANO ORTHOPEDIC
Sports Medicine & Spine Center, P.A.

Allan N. Sutker, M.D., P.A.
Sports Medicine
Arthroscopic Surgery of the Knee and Shoulder
Orthopedic Surgery

F. Alan Barber, M.D., FACS, P.A.
Arthroscopic Surgery of the Knee and Shoulder

Purcell Smith, III, M.D., P.A.
Surgery of the Hand, Wrist, Elbow
Orthopedic Surgery

Earl R. Lund, M.D., P.A.
Surgery of the Hand and Upper Extremity
Arthroscopic Wrist Surgery

Randal L. Troop, M.D., P.A.
Sports Medicine
Arthroscopic Surgery of the Knee and Shoulder
Orthopedic Surgery

Stephen P. Courtney, M.D., P.A.
Reconstructive Surgery of the Neck and Back
Orthopedic Surgery

John M. Crates, M.D., P.A.
Orthopedic Surgery
Arthroscopic Surgery
Surgery of the Foot and Ankle

Kenneth S. Dauber, M.D., P.A.
Physical Medicine and Rehabilitation

Cameron N. Carmody, M.D., P.A.
Reconstructive Surgery of the Neck and Back
Orthopedic Surgery

Solomon H. Chaim, M.D., P.A.
Surgery of the Foot and Ankle
Orthopedic Surgery

William K. Montgomery, M.D., P.A.
Total Joint Replacement

Disclosure

The Plano Orthopedic physician you are seeing may have a financial interest in the following facilities:

Baylor Medical Center at Frisco
5601 Warren Parkway
Frisco, TX 75034
(214) 407.5000

Surgery Center of Plano
1620 Coit Road
Plano, TX 75075
(972) 519.1100

Texas Health Center for Diagnostics & Surgery
6020 West Parker Rd
Plano, TX 75093
(972) 403-2700

Preston Plaza Surgery Center
17950 Preston Rd, Ste 75
Dallas, TX 75252
(972) 267.5400

Plano Therapy Center
3405 Midway, Ste 500
Plano, TX 75093
(972) 473.0229

Allen Therapy Center
1223 W McDermott, Ste 50
Allen, TX 75013
(972) 359.1288

North Star MRI (Frisco)
8501 Wade Blvd., Ste 220
Frisco, TX 75034
(214) 618.3420

North Star MRI (Allen)
997 Raintree Circle, Ste 110
Allen, TX 75013
(972) 954.8001

North Star MRI (Plano)
3700 W 15th St Bldg D #200
Plano, TX 75075
(972) 758.9000

The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality care for you.

Should you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Signature: ______________________________ Date: _______________