The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

Disclosure of Ownership

Providers are required by Texas law (SB 872, 2005) to disclose ownership or financial interest in any health care facilities where their patients may receive medical care. Richard G. Buch M.D. respect the rights of patients to not only choose their surgeon but also where they wish to have their surgery completed.

Richard G. Buch, M.D. has ownership in Legent Hospital for Special Surgery in Plano, Texas. This facility is a private, state of the art facility that is owned by many health care providers interested in bettering the health of the community through a more efficient and personalized delivery of health care. The facilities are fully accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO). We encourage our patients to discuss any questions or concerns they may have with DLRC at any time so that they may make informed decisions regarding their medical care.

I have read and understand the above disclosures.

Patient Name:_____DOB:_____

Signature:_____Date:_____

Name of Person Signing if not Patient:_____

Relationship to Patient:_____

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

HIPAA Information Sheet

I hereby give permission to Richard G. Buch, M.D., PA to disclose and discuss any information related to my medical condition(s) with the following family members(s), other relative(s) and/or close personal friend(s):

Name:_____

Relationship: _____

Phone Number(s): _____

Name: _____

Relationship: _____

Phone Number(s):_____

Name: _____

Relationship:_____

Phone Number(s): _____

☐ I do not wish to give permission for additional family members, relatives and/or close personal friends to have access to any information regarding my medical condition(s).

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Cell: _____ Work: _____Home: _____

☐ OK to leave message with detailed information at home
☐ OK to leave message with call back number only at home
☐ OK to leave message with detailed information at work
☐ OK to leave message with call back number only at work
☐ Written communication only
☐ OK to send mail to home address
☐ OK to send mail to work/office address at: _____

_____

_____

☐ OK to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information form persons not listed above will requires specific authorization prior to disclosure of any medical information.

Patient Signature: _____ **Date**: _____

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrolton, Texas 75010
(469) 443-0924

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

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use or disclose limited amounts of your protected health information to send you fundraising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA and HITECH regulations.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of January 1, 2020.

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

Authorization for Release of Information and Assignment of Benefits

I hereby authorize The Dallas Limb Restoration Center to furnish information to my insurance carriers and my referring doctors on behalf of myself and/or my dependents; and hereby assign The Dallas Limb Restoration Center all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment of services as determined by my insurance company. I permit a copy of this authorization to be used in place of the original.

Initial: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered and/or received a copy of The Dallas Limb Restoration Center "Notice of Privacy Practices". This notice describes how The Dallas Limb Restoration Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial: _____

Authorization for Media Release

The Dallas Limb Restoration Center is grateful for patients who are willing to share information about their treatment, our office, physician, and staff as your experiences can be helpful to others who are seeking orthopedic care. However, protecting the privacy of our patients and their confidential information are among our highest priorities. Therefore we seek permission from our patients, their families, or guardians to use any photographs and or video images taken for the purpose of publication, promotion, illustration, or advertising. This information is sought to be used in a educational manner for official Dallas Limb Restoration Center communications.

I hereby release The Dallas Limb Restoration Center and its representatives for all claims and liability relating to said images or video. This permission may include both electronic and printed versions of material produced by The Dallas Limb Restoration Center. By granting this permission I also herby release and waive claims to compensation regarding such use and publication.

Initial: _____

Patient Name: _____

_____
(Signature of Patient, or Legal Personal Representative) Date

_____
(Name/Relationship to Patient if Applicable) Date

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

Letter of Medical Necessity

Toxicology Testing

- The patient is prescribed controlled medications. The drug screen will be used to identify any non-prescribed medications or illicit use for ongoing safe prescribing of controlled substances and reduce the risk of adverse reactions.

- Testing ordered to establish baseline levels for a new patient. The drug screen will be used to identify and non-prescribed medications or illicit drug use. Confirmation testing ordered to rule out an error as the cause of a presumptive UDT result.

- Urine drug screen and Confirmation ordered today due to DEA regulations for opiate medication management. Drug screen will be used to identify any non-prescribed medications. Confirmation testing ordered to rule out an error as the cause a presumptive UDT result.

Other: _____

Printed Patient Name: _____

_____
(Signature of Patient, or Legal Personal Representative) Date

_____
Name/Relationship to Patient if Applicable) Date

Richard G. Buch M.D.

_____
Physician Name Physician Signature Date

Note: Each of the considerations selected above for testing has been made according to FDA approved prescribing information, published clinical guidelines, and/or published clinical evidence in conjunction with my clinical assessment. This form is meant to be an aid to assist clinicians in documenting key elements of ordering and implementing toxicology results and does not replace all documentation that should be included in the medical record or might be required by a different health plan/payors or regulatory systems.

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

History Intake

1. Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____

2. Hand dominance: Which hand do you use most often? RIGHT LEFT BOTH

3. Chief complaint(s): Why are you here today? _____

Was this an injury? Yes No **Date of Injury:** _____/_____/_____

***Briefly* Describe the injury (i.e. twist, fall, etc.):** _____

Was this work-related? Yes No **If yes, please complete the *Worker's Compensation Form***

4. History of current complaint: Tell us more about your problem.

Location: *Where* is the problem located? **RIGHT** **LEFT** **BOTH**

Shoulder Elbow Wrist Hand Hip Knee Ankle Foot Other_____

Severity: For below, 0 is NO pain and 10 is the WORST pain you can possibly imagine

How intense is your pain right now? ***0 1 2 3 4 5 6 7 8 9 10***

How intense is your pain at is worst? ***0 1 2 3 4 5 6 7 8 9 10***

How intense is your pain at its least? ***0 1 2 3 4 5 6 7 8 9 10***

What is the average intensity of your pain? ***0 1 2 3 4 5 6 7 8 9 10***

Describe your pain: Achy Sharp Dull Burning Other:_____

Associated Symptoms: Swelling Catching Locking Buckling Numbness Tingling Other:_____

How long* have you had this problem**? _____ ***Is your problem: Constant or Intermittent

***When* does it occur?** Morning Daytime Afternoon Night With activities At rest

Does your pain wake you at night? Yes No

What makes it *worse?* Reaching overhead Lifting Sitting Standing Walking Squatting Running Other:_____

Do you have: *pain/difficulty with stairs?* Yes No *Pain/difficulty putting on socks or shoes?* Yes No

What makes it *better?* Ice Rest Positional changes Activity modification (avoidance) Other:_____

Walking Aids: *Do you use: cane walker crutches wheelchair motorized* scooter

5. Previous treatments: How has your problem been treated in the past?

Medications. Which ones? _____
Physical Therapy. *For how many weeks?* _____ *Approximate date of completion:* _____/_____/_____
Injections. *Type?* Steroid Gel or Lubricant PRP Stem Cells *Date of LAST injection:* _____/_____/_____
Other: _____

Did any of these treatments help? Yes No Please explain. _____

6. Past Medical History (Check all that apply.) **Check here if none**

High blood pressure	Hypothyroidism	Stomach Ulcers	Blood Transfusion
High Cholesterol	Rheumatoid Arthritis	Bleeding Disorder	HIV, Last CD4:_____
Heart Attack	Asthma	Blood clots/DVT	Hepatitis C
Congestive Heart Failure	Sleep Apnea/CPAP	Pulmonary embolism	Cancer, Type:_____
Arrhythmia (i.e. Atrial Fib)	Pneumonia	Peripheral Neuropathy	Fibromyalgia
Pacemaker	Lung Disease/COPD	Anxiety	Chronic Pain
Peripheral vascular disease	Liver Disease	Depression	Pain Management Doctor
Stroke	Kidney Disease	Bipolar	Nerve stimulator
Diabetes	Reflux/GERD	Dementia	Other:

7. Past Surgical History **Check here if none** **Check here if separate sheet attached**

Surgery	Year	Surgery	Year	Surgery	Year
1.		**3.**		**5.**	
2.		**4.**		**6.**	

Have you ever had complications with anesthesia? No Yes **Explain:** _____

8. Current Medications Check here if none Check here if separate sheet attached

Name	Dose	Frequency	Name	Dose	Frequency
1.			**4.**		
2.			**5.**		
3.			**6.**		

9. Allergies: _____ **Check here if none**

10. Family History **Check here if none**

High blood pressure	Stroke	Bleeding Disorder	Anxiety
High Cholesterol	Diabetes	Blood clots/DVT	Cancer, Type:_____
Heart Attack	Rheumatoid Arthritis	Depression	Other:

11. Social History

Occupation:		Retired? Yes No
Marital Status:	Single Married Divorced Widowed Significant other	
History of drug use?	Yes Marijuana Heroin Crack/Cocaine Other:_____ No Date of last use: ____/____/____	
Do you drink alcohol?	Never (or rarely) Daily 1 to 3 times per week 1 to 3 times per month	
Do you smoke?	No Yes Packs per day:_____ Number of years:_____ I quit _____ years ago	
Smokeless tobacco?	No Yes Type and Frequency:	

12. Review of Systems (please check *any* that apply) **Check here if nothing to report**

General	Psychiatric	Neurological	Endocrine
Fever/Chills	Excessive worry	Seizures	Excessive thirst
Fatigue	Depressed mood	Numbness/tingling	Cold or heat intolerance
Night sweats	Hallucinations	Weakness	Excessive urination
Respiratory	**Heart**	**Genitourinary**	**Blood**
Wheezing	Chest pain	Painful urination	Anemia
Chronic cough	Palpitations	Blood in urine	Hemophilia
Short of breath	Irregular pulse	Difficulty urinating	Easy bruising
Productive cough	Heart murmur	Urinary infections	Sickle cell
Tuberculosis	Swelling in legs	Incontinence	Blood clots
Bones/joints	**GI**	**Allergy/Immune**	**Skin**
Joint Pain	Nausea	Metal allergies	Rashes
Joint Swelling	Vomiting	Immune disorders	Skin cancer
Joint Stiffness	Ulcers	Latex allergy	Psoriasis
Back Pain	Abdominal Pain	Seasonal allergies	Open sores

Patient Signature:_____ **Date:** _____/_____/_____

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

Prescription Policy

All medication, including refills are prescribed based on your current condition. If medication is prescribed, you will be subject to a urine toxicology test to establish a baseline. Follow up appointments are scheduled to monitor your conditions and additional testing may be required.

If you are referred to pain management or are currently under the care of a pain management physician, DLRC will no longer provide narcotic medications even if you decide to no longer seek care from that pain management specialist.

New Medication Requests: New medications will not be prescribed via fax request from your pharmacy. You must call the office and leave a detailed message. If you have cancelled, no-showed, or rescheduled your appointment more than one time your refill requests may not be processed.

Non-Narcotic Medications: Refill requests should be made to your pharmacy who will in turn notify our office. If you have cancelled, no showed, or rescheduled your appointment more than one time your refill requests may not be processed.

Narcotic Medications: Narcotic medications (ex. Norco, Percocet, etc...) requiring a paper triplicate prescription will only be prescribed and refilled if the patient meets all the following requirements:

1. Patient is within 90 days of surgery performed by DLRC.
2. Patient has documented medical necessity for narcotic use beyond 90 days post operatively in their DLRC medical record.
3. Has completed an annual narcotic clinical analysis appointment and urine drug screen.
4. Has completed all necessary follow-up appointments.
5. Has read and signed the prescription policy form.

Prescription requests received after 3:00 pm will not be processed until the next business day. Medications WILL NOT be refilled on weekends, holidays or by our on call providers. Therefore, it is your responsibility to call the pharmacy for refills at least 24 hours prior to running out of medication.

Patient Name: _____

Pharmacy Name: _____Pharmacy Phone_____

Pharmacy Location/Cross Streets _____

_____
(Signature of Patient, or Legal Personal Representative) Date

_____
(Name/Relationship to Patient if Applicable) Date

The Dallas Limb Restoration Center
Richard Buch, M.D.
Angela Mealing, MSN, APRN, FNP-C, RNFA

4333 N. Josey Lane, Plaza II, Ste. 100B
Carrollton, Texas 75010
(469) 443-0924

Office Policies

1. **OFFICE VISIT -** A valid *CURRENT* insurance card and photo ID must be available at each office visit. Payment is expected at the time services are rendered. We will help you by filing your insurance for the covered portion. The deductibles and non-covered portions are due at the time of service. For your convenience, we accept cash, check, and credit cards; Visa, American Express, MasterCard. If you are more than ***30 minutes*** late, we may need to reschedule your appointment. Most insurance plans cover 80-100% of your visits. Some insurance policies have deductibles and/or copayments; some do not. ***THIS IS DUE AT CHECK IN.*** If your insurance does not pay its portion within sixty days, you will be called upon to assist in the collection/payment process. Regrettably, it is possible that an appointment may be delayed or rescheduled when accounts are significantly behind. **Initial:** _____

2. **MEDICAL INSURANCE** - Medical insurance plans vary widely in their coverage of services. Your contract is an agreement between you and the insurance company. This contract does not obligate the doctor to charge a specific fee or to accept reimbursement from your insurance company as payment in full, unless the contracted amount is paid on time. You will remain responsible for the uncovered balance. Complaints or inquiries about insurance coverage should be directed to your insurance carrier. **Initial:** _____
   WE DO NOT BILL AUTO INSURANCE OR THIRD PARTY LIABILITY INSURANCE.

3. **PREAUTHORIZATION OF BENEFITS** - In some instances, pre-authorization of benefits is required from your insurance carrier. ***If required it is your responsibility to obtain the pre-authorization***. If you decide to forego the pre-authorization, then you are totally responsible to pay personally at the time of services. Pre-authorization are limited to the dates approved. **Initial:** _____

4. **MISSED APPOINTMENTS** - We require ***one full business day*** notice to reschedule or cancel an appointment (for example, call Friday morning regarding the following Monday). Our no-show policy fee for a ***broken appointment is $50.00*** for less than 1 (one) business day of notice. We do understand that things beyond your control can occur. If this is the case, please call. **Initial:** _____

5. **COLLECTIONS** - All charges are payable within sixty (60) days. Unpaid accounts force us to raise our fees, and to terminate service for the respective patient. Because of this, we are committed to pursue any unpaid account balances. Unpaid accounts will be referred to a professional collection agency, ***(50% charge added to accounts referred to collections)*** or pursued in the courts; NSF checks must be refunded to us immediately. Fee of $25.00 plus the amount of the check due immediately; payment in cash, money order or cashier's check. If you have a financial problem, special arrangements can be made if notification is given to our office at the earliest possible moment. **Initial:** _____

6. **TEST RESULTS** - Diagnostic testing results (MRI, CT, biopsies, etc.) return at different times and may take as long as two weeks. The results are monitored and checked as they arrive. Abnormal results often require prompt attention/action and you will be notified immediately. Otherwise, all results are given to the physician and he will discuss the results with you at your next appointment. ***Unless specifically instructed to do so, please do not call the office for results.*** **Initial:** _____

7. **TELEPHONE CALLS** - Patients sometimes become upset when they call the office and cannot get through to the doctor. Our staff is trained to handle all in-coming telephone calls. This procedure allows us to attend to the patients with a minimum of interruptions. ***PLEASE*** be patient, this is a courtesy that you would want observed if you were the patient in the office at the time. ***REPEATED CALLS for the same reason will not facilitate your call***. Your call will be handled as soon as possible, if not immediately. **Initial:** _____

8. **FORMS, LETTER AND MEDICAL RECORDS** - There is a charge for forms that we must complete, or letters that we write. ***PRE-PAYMENT IS REQUIRED***. Disability forms require 14 days to complete. Medical records require authorization and we strictly adhere to HIPAA rules and regulations. Forms and correspondence completion are payable in advance (physician to physician is a free service). **Initial:** _____

9. **SURGERY** - If a surgical procedure is necessary, a deposit may be required depending on your insurance plan. If there is an applicable deductible and/or co-insurance due it will be collected ***PRIOR*** to your procedure. It is recommended that you contact your insurance carrier to understand your benefits and what you may or may not be responsible for, especially if surgery is anticipated. In the case that you would need to cancel a surgery, we require a minimum 24 hour notice of cancellation or you will be subject to a $350.00 cancellation fee. **Initial:** _____

10. **MULTI MEDIA COMMUNICATION/DATA SHARING:** DLRC requests permission to discuss and store your private health information with yourself and providers directly caring for you through media sources such as e-mail, text, images, etc...If you permit the use of multi-media use of your protected health information, please. **Initial:**_____

Patient Name: _____

_____

(Signature of Patient, or Legal Personal Representative) Date

_____

(Name/Relationship to Patient if Applicable) Date