ROC
RECONSTRUCTIVE ORTHOPEDIC CENTER
- HOUSTON -

WELCOME TO THE RECONSTRUCTIVE ORTHOPEDIC CENTER OF HOUSTON

Below you will find general information regarding our therapy department and your treatment. We hope this handout will provide information that will make your visit with us as pleasant and smooth as possible.

- **Hours of operation:** 8:00am to 5:00pm, Monday through Friday. The last appointment before lunch is at 11:00am and the last appointment of the day is at 3:30pm.

- **If you require a specific time for your appointment:** We will accommodate your schedule when possible, but please schedule your times in advance (2 weeks at a time) to make sure the times are available for you.

- **Waiting for appointments to begin:** If you are early for your appointment it will be difficult for us to start your therapy early. We want all patients to receive their allotted time for treatment and have scheduled this accordingly.

- **Arriving late for appointments:** If you are late for your appointment, the therapist may reschedule you for another time as necessary. If you arrive on the wrong day, you will be reschedule unless there is a treatment time available. Please be considerate of other patients; if you arrive late this interferes with their scheduled appointment time.

- **If you have to cancel an appointment:** Please cancel your appointment at least 24 hours in advance. We often have patient waiting to schedule, so with 24 hours notice we can rebook your appointment time that you had cancel. If you are filing worker's compensation and miss an appointment, we are obligated to send a notice to both your insurance company and the doctor that you missed your appointment. Missed visits must be captured in the same week.

- **Cell phones cannot be used inside the clinic** unless you work in an emergency profession where your phone is used to contact you in an urgent situation. Unnecessary phone calls limits you and the therapist's valuable treatment plan. Also, cell phones can cause patient's heart pacemakers to malfunction.

- **Limiting visitors and children in the clinic:** Family and children need to wait in the waiting room due to the privacy and safety of themselves and our other patients. We have unfortunately found that children can be disruptive and cause the patient not to get the proper therapy time, while family members take up seats and space that other patients may need.

- **Scheduling with your primary therapist:** Please schedule whenever possible with your primary therapist in order to ensure continuity of care. You will meet your primary therapist on your first day of treatment. Our therapist work closely with certified assistants (COTA's) who will also be involved in your treatment. These assistants are trained in hand rehabilitation and carry out treatment plan outlined by your primary therapist. The primary therapist will be tracking your progress and making changes to your treatment plan necessary. If you have any issue regarding your treatment you should always discuss it with your primary therapist.

- **Co-Payments and Splints are due at the time of service.** PPO and Self individuals will need to make their payments after each session.

- **After each therapy visit, please check out at the front desk before you leave.** Your charge sheet will be processed by the secretary and any other treatment or insurance issue will be discussed.

- **If your insurance requires a referral from your PCP** (Primary Care Physician), it will be your responsibility to confirm that there is a valid referral for each visit. In addition, you need to be aware that some Insurance Companies only allow 60 days of consecutive treatment per diagnosis, per calendar year.

- **Parking building is available around the building and at the covered garage for free.**

(Sign here)_____I have read all of the above information and will comply with the rules and regulations above.

Our therapist are:

Kathy Brou, OTR, CHT
Francisco Mendoza, MOT, OTR
Debra Miller, MHSPT, CHT
Joanna Ford, COTA

Therapy tech:
Tacarrington Ray

ROC
RECONSTRUCTIVE ORTHOPEDIC CENTER
- HOUSTON -

PATIENT CONSENT FORM

Patient's name:_____

CONSENT TO TREATMENT

Knowing that I have a condition-requiring Healthcare, I voluntarily consent to such care, including diagnosis procedures and medical treatment ordered by my physicians. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment or examinations, **Initial here**_____**.**

ACCIDENTAL EXPOSURE OF HEALTHCARE WORKER

I understand that, if a health care worker is accidentally exposed to my blood or other bloodily fluid, I will be tested for Hepatitis B, Hepatitis C and/or HIV/AIDS without my specific consent. Test results will be kept confidential to the extent allowed by law. **Initial her**_____**.**

TOBACCO-FREE ENVIRONMENT

I am aware that Reconstructive Orthopedic Center of Houston prohibits the consumption, use of possession of non-prescribe drugs, alcohol and weapons on Reconstructive Orthopedic Center of Houston's property. If non-prescribe drugs, alcohol and weapons are found, they will be confiscated, and I may be discharged immediately. Local police department will be notified, as necessary. **Initial here**_____**.**

FINANCIAL RESPONSIBILITY

I promise to pay Reconstructive Orthopedic Center of Houston, PA physician, supplier and other practitioner for services rendered in accordance with bills or invoices presented. If I participate in an insurance benefit plan, I acknowledge financial responsibility, in accordance with the term of the plan, for any services rendered that my insurance does not cover from payment either, because the plan deems such services not medically necessary or for any reason. **Initial here**_____**.**

PLEASE CHECK ALL THAT APPLY:

___**ASSIGNMENT OF BENEFITS.** I irrevocably assign to Reconstructive Orthopedic Center of Houston all insurance benefits payable to me under my policies for hospital and professional services rendered to me.

___**MEDICARE ASSIGNMENT.** I certify that the information given to me in applying for Medicare benefits is correct. I request that payment of authorized benefits be made directly to Reconstructive Orthopedic Center of Houston.

___**MEDICAID ASSIGNMENT.** I certify that the information given to me in applying for Medicaid benefits is correct. I request that payment of authorized benefits be made directly to Reconstructive Orthopedic Center of Houston.

___**WORKER'S COMPENSATION.** The Worker's Compensation Commission regulates fees and charges for medical aid, hospital services and medicines. I understand that, if the Insurance Carrier determines that my injury is not considered compensable and if choose to continue with my therapy with this knowledge, I will be responsible for the charges incurred.

___**PHOTOGRAPH RELEASE.** I consent to have audio or visual recordings in the form of photograph, illustrations, or videotapes made of me to be used for educational or research purposes. **Initial here_____.**

___**PERSONAL ITEMS.** I have been advised to leave my personal items at home and assume full responsibility for any personal item that i can take to my therapy appointments. I understand that Reconstructive Orthopedic Center of Houston will not be responsible for any personal items that are lost, stolen or damaged. **Initial here_____.**

This consent form is valid unless otherwise changed. i certified that I have read the above information, or that the information has been read or translated to me, and that i understand my rights and responsibilities as a patient at Reconstructive Orthopedic Center of Houston. All photocopies of this form shall be considered as originals.

_____ _____

Signature of patient of guardian **Date**

_____ _____

Witness **Date**