



**WILLIAM K. MONTGOMERY, M.D.**

5228 W. Plano Parkway  
Plano, TX 75093  
972-250-5700  
972-250-5747 (fax)

Dear Patient,

The following forms need to be filled out before you come to your appointment. Filling out these forms completely and accurately will expedite the registration process. Thank you in advance for your time. We look forward to seeing you in the office.

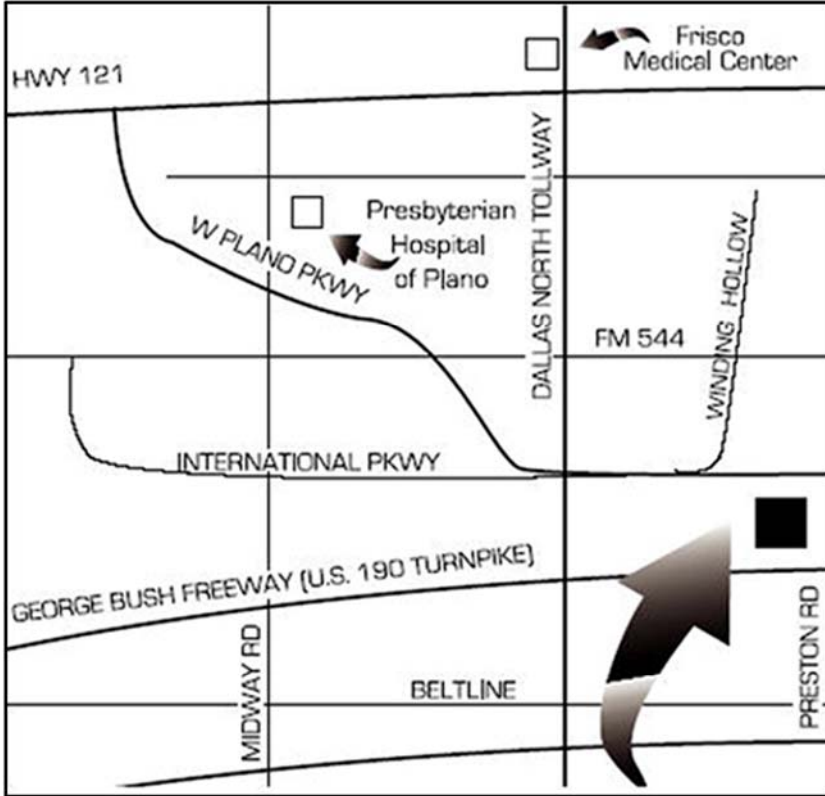
1. Patient Information Form (2 pages)
2. Authorization for Use and Disclosure of Protected Health Information (PHI)
3. Prior Medical History and Review of Systems (4 pages)
4. Patient Assessment and Treatment Outcomes (2 pages)
5. Regarding Insurance Correspondence
6. Medical Record Release Form
7. Universal Injury, Condition and/or Accident Statement

The staff of William K. Montgomery, M.D.



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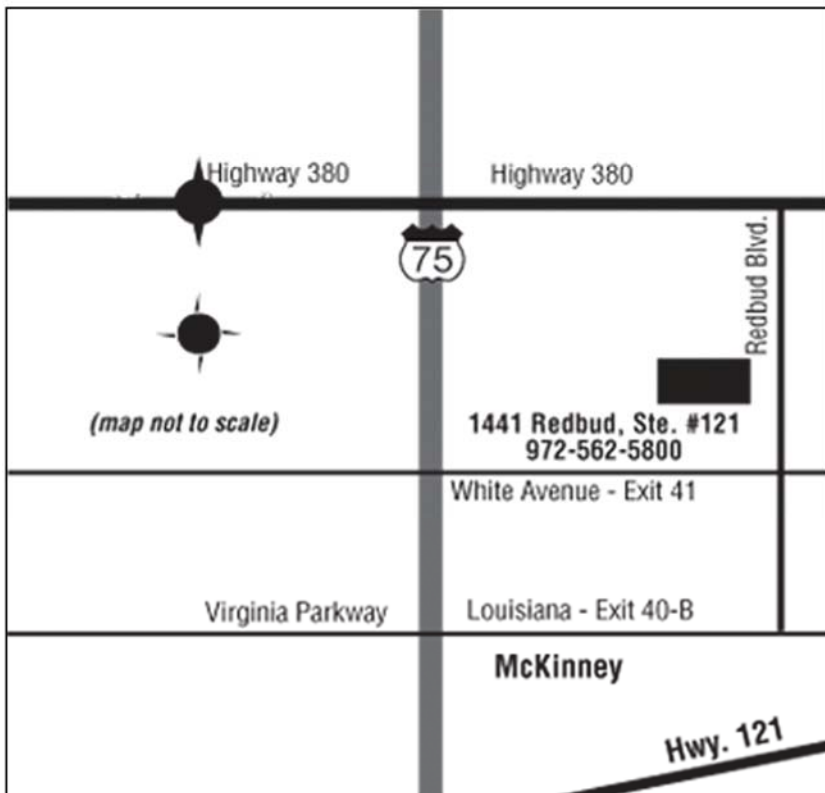


The Plano office is located at:

5228 W. Plano Parkway  
Plano, TX 75093  
972-250-5700  
Fax 972-250-5747

**Driving instructions:**

Exit the Dallas North Tollway onto Plano Parkway and turn east toward Preston. The office is located at the intersection of Winding Hollow and Plano Parkway, across from Shepton High School.



The McKinney office is located at:

1441 Redbud, Ste. 121  
McKinney, TX 75069  
972-250-5700 (for scheduling)  
972-562-5800 (office)

**Driving instructions:**

Exit U.S. 75 (Central Expressway) onto White Street (Exit 41). Go east to Redbud Blvd. Go north to Heritage Medical Building and turn north into the parking lot.



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**REGARDING INSURANCE CORRESPONDENCE**

Changes in the insurance industry, particularly “managed care” including PPOs, HMOs, and others, have led to an unacceptable volume of phone and mail correspondence, notes, letters, and other requirements that have no direct impact on patient care but require an increased overhead of office personnel and expense.

Effective immediately, our office will correspond *once* at no charge with your primary carrier for charges incurred directly resulting from a specific visit or procedure performed by us. **ANY OTHER CORRESPONDENCE** required by your insurance company or your work is YOUR RESPONSIBILITY and will incur an additional \$20.00 charge for Preparation and Handling, including the doctors’ or staff person’s time. This fee will be payable in advance, at the time the forms are presented. These will include but are not limited to:

- Disability forms, family medical leave forms
- Letters for “medical necessity” of prescriptions or diagnostic tests
- Coordination of more than two insurance carriers
- Protracted precertification procedures requiring multiple phone calls or letters
- Other correspondence requiring extended staff time, letters, calls, etc.

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

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

## Universal Injury, Condition and/or Accident Statement

**Patient Name** \_\_\_\_\_  
Full Name

**Today's Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

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 I "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 Orthopedic and Sports Medicine Center**

Authorization for Disclosure of Confidential Information

**(Medical Record Release)**

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

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

**I authorize Plano Orthopedic and Sports Medicine Center to release my  
medical records to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

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

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

**Please fax the medical release to 972-250-5749**