

Orthopaedic Specialists, P.L.L.C.

PATIENT INFORMATION

Date: _____

Patient's Last Name			First				Middle Initial		Home Phone No.	
Street Address			City and State				Zip Code		Cell Phone No.	
Social Security No.	DOB	Age	Sex			Marital Status				
			M	F	S	M	W	D	P	E-mail Address
Patient's Employer	Occupation		Employer's Street Address				City, State and Zip		Business Phone No.	
Spouses Name (or Parents if Child)	Occupation		Spouse/Parent Employer Name				City, State and Zip			

Are You Here Due to an Injury? If Yes, what type: Auto Work Other Date of Injury or Accident: _____

If Injury or Accident will you be filing car insurance, workers compensation, or liability insurance: Yes or No

Emergency contact not living with you

Name _____ Relationship to Patient _____ Phone number _____

INSURANCE INFORMATION

IMPORTANT: INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY IN ORDER TO FILE A CLAIM

Primary Insurance Co. Name				Secondary Insurance Co. Name			
Group #		ID#		Group #		ID#	
Name of Responsible Party for bill		Amount of Co-pay, if applicable		Effective Date of Coverage		Amount of Co-pay, if applicable	
		\$				\$	
Name of Policyholder: If the same as patient check here <input type="checkbox"/>				Name of Policyholder: If the same as patient check here <input type="checkbox"/>			
Address and Phone Number of Policyholder				Address and Phone Number of Policyholder			
Policyholder Home Phone No.		Work Phone No.		Policyholder Home Phone No.		Work Phone No.	
Policyholder DOB		Sex		Policyholder DOB		Sex	
Consultation requested by (referring Physician) OR Who referred you to our practice?				Full Name of Family Physician			

INSURANCE AUTHORIZATION, ASSIGNMENT and CONSENT TO TREAT

I hereby authorize Orthopaedic Specialists, P.L.L.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance

Signature of Patient or Parent/Guardian (if minor) _____ Date: _____

ORTHOPAEDIC SPECIALISTS, PLLC

Financial Policy for Patient Care Services

To help provide the most efficient and reasonable health care service, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have **accurate** and **complete** information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days.

If you have insurance and we file with your carrier, we require payment of balances which are deemed your responsibility (co payments, deductibles, co-insurance) at the time the service is received. We ask that you please contact your insurance company if your claim has not been paid within 30 days.

Patient “no shows” and cancellations are a tremendous loss for a practice. Please help our office reduce losses by canceling with at least a 48 hour notice. *Failure to give notice 24 hours prior to your scheduled time may result in a \$50.00 fee to be paid by the patient.*

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a “Self Pay” patient, or for the amount of any deductible, co payments or coinsurance. If you are unable to meet your financial obligation, you may be asked to reschedule. If you are a “Self Pay” patient, please see the receptionist for an additional “self pay” policy.
3. Please be prepared to present your insurance card to the receptionist upon signing in. If you cannot provide a copy of your insurance card, you will be considered “Self Pay” and will be required to pay for services in full on the date they are received. Upon receipt of insurance information, and in the event your insurance pays your claim, you will be refunded the amount of the credit due to you at that time.
4. Understand that we, from time to time, may verify insurance benefits on your behalf. Please be aware that we cannot be responsible for misinformation received from your insurance company. Insurance companies have a disclaimer for all callers stating that the benefits given over the phone are only an estimate and that the benefits are not determined until the actual claim is paid. Therefore, it is not possible for us to guarantee any type of coverage or benefit on your behalf.
5. Further understand that there is a charge of \$20.00 for each disability or FMLA form that is completed on your behalf.

Patient Signature

Date

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Orthopaedic Specialists uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Orthopaedic Specialists will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Orthopaedic Specialists may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Orthopaedic Specialists may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of you health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Orthopaedic Specialists must maintain the privacy of protected health information, provide your with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact the Privacy Officer at (502) 212-2663.

I, _____, understand that in the case that I may need someone other than myself to obtain medical information (medical records, prescriptions, or phone calls for examples) for me from the office, their names needs to be listed BELOW.

Name of authorized person(s)

Name of authorized person(s)

Patient Signature or authorized representative

Date

Printed name if signed on behalf of patient (parent, legal guardian, personal representative, etc.)



Consent for Release of Prescription History

This is for your safety!!! Dr. Grossfeld is requesting information to access your prescription information because this is the MOST accurate and efficient way to place your medication list in your electronic health record. This can help PREVENT dangerous drug interactions, duplication of similar medications and allergic reactions. It is very important that she have a complete list of all your medications and doses. Accessing the prescription history is going to make this process accurate and safe.

I authorize Orthopaedic Specialists PLLC, to access my prescription history from unaffiliated medical providers, insurance companies, and pharmacy benefit managers, to help keep my medical records as complete as possible. I understand that my prescription history from other sources may be viewed by the providers and staff within Orthopaedic Specialists PLLC, and may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONCENT AND THAT I AUTHORIZE THE ACCESS.

Printed Name

Date

Patient Signature

Date

History and Physical
New Patient or Established Patient updated yearly
Orthopaedic Specialists Dr. Stacie Grossfeld

1. Name

Date:

2. Who referred you to our office?

3. Who is your primary care physician?

4. Occupation

5. Age _____ Weight _____ Height _____ BP _____ Right or Left Handed _____

6. Reason for Consultation with Dr. Grossfeld

7. Where is the pain located?

8. What is the mechanism of injury that started your symptoms or was there an injury?

9. What is the duration of your symptoms? (how long has your pain been present)

10. What is the quality of the pain? sharp / dull / throbbing

11. Rate your pain on the VAS pain scale: Zero is no pain and 10 is the worse pain you have ever experienced (circle the number)

0 -----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

12. Have your symptoms limited your activities, if so how?

13. What is your present treatment for this problem?

14. What is the past treatment for your symptoms?

FOR PHYSICIAN USE ONLY

X-ray Results

Plan

15. Please list medications taken for this problem (example: Aleve, Mobic, etc.)

16. Have you had an MRI for this problem, if so location and date?

Please Check yes or no.

Past Personal History

Y N High blood pressure

Y N Heart Condition

Y N Gout

Y N Hyperthyroidism

Y N Diabetes

Y N Emphysema

Y N Hypothyroidism

Y N Cancer

Please list type

Y N Stroke

Y N Congestive Heart Failure

Y N Blood Clots

Y N Pulmonary Embolus

Family History

Y N High blood pressure

Y N Heart Condition

Y N Gout

Y N Hyperthyroidism

Y N Diabetes

Y N Emphysema

Y N Hypothyroidism

Y N Cancer

Please list type

Y N Stroke

Y N Congestive Heart Failure

Y N Blood Clots

Y N Pulmonary Embolus

HIV Positive? Yes No

Hepatitis C Positive? Yes No

Please list types of surgeries and dates performed:

Social History

Marital Status: Single Married Divorced Widowed Partner

Do you have children? No Yes How many?

Do you live alone? Yes No Who lives with you?

Do you smoke?

Yes, I've smoked _____ packs of cigarettes per day for _____ years

No, I have never smoked

No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years

Do you drink alcohol?

No, never (or rarely)

No, but I used to

Yes Daily 1 or more times per week 1 or more times per month

Name _____ DOB _____ Date _____

Constitutional:

N/A No Yes Dizziness
N/A No Yes Fever
N/A No Yes Night sweats

Eyes:

N/A No Yes Cataracts
N/A No Yes Visual disturbance
N/A No Yes Macular Degeneration

Ears/Nose/Throat/Neck:

N/A No Yes Hearing loss
N/A No Yes Nosebleeds
N/A No Yes Sinus problems

Cardiovascular:

N/A No Yes Chest pain
N/A No Yes Palpitations
N/A No Yes Chest pressure

Respiratory:

N/A No Yes Emphysema
N/A No Yes Apneic episodes
N/A No Yes Shortness of breath

Gastrointestinal:

N/A No Yes Rectal bleeding
N/A No Yes Heartburn
N/A No Yes Abdominal pain

Genitourinary/Nephrology:

N/A No Yes Blood in urine
N/A No Yes Urinary difficulties

Musculoskeletal:

N/A No Yes Back pain
N/A No Yes Muscle weakness
N/A No Yes Joint pain

Dermatologic:

N/A No Yes Keloids/hypertrophic scars
N/A No Yes Skin rash
N/A No Yes Ulcerations

Neurologic:

N/A No Yes Impaired balance
N/A No Yes Dizziness
N/A No Yes Seizure

Psychiatric:

N/A No Yes Addiction to alcohol
N/A No Yes Addiction to medication
N/A No Yes Depression
N/A No Yes Anxiety

Endocrine:

N/A No Yes High blood sugar
N/A No Yes Menstrual cycle irregularity
N/A No Yes Perimenopausal symptoms

Hematologic/Lymphatic:

N/A No Yes Prolonged bleeding
N/A No Yes Blood clotting problem
N/A No Yes Easy bruising

Allergy/Immunology:

N/A No Yes Hives
N/A No Yes Eye itching
N/A No Yes Eyelid swelling

MD Signature _____

PATIENT MEDICATION LIST

MEDICATION <small>****(Including Vitamins and Herbs)****</small>	DOSAGE	FREQUENCY/NUMBER OF TIMES A DAY	WHAT IS IT FOR?

ALLERGIES TO MEDICATION			

Date

Patient Signature

I have had no medication changes since my last visit on _____

 Patient
 Signature