



ORTHOPEDICS TODAY

Today's Date: _____

Patient Name: _____
Last First Middle Initial
 Date of Birth: _____ Age: _____ Social Security Number: _____ Gender: M F
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____ Employer: _____ Job Title: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Primary Care Physician: _____ Referring Physician: _____

In order to better serve you, ethnicity information has been requested by certain insurance companies.

Ethnicity (Please Circle): African American Asian Cuban Hispanic/Latino Irish Italian
Jewish Multiracial Native American Polish Caucasian Declined

Race (Please Circle): American Indian Asian Indian Black Chinese Filipino Guamanian Hawaiian
Hispanic Japanese Multiracial Samoan Vietnamese White Declined

Date of Injury (if applicable): _____ **Is this a work-related injury?** Yes No

Worker's Compensation Information (If Applicable, please fill out completely)

Claim Number: _____ Employer Name: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____
 Employer Phone: _____ Adjustor Name: _____ Adjustor Phone: _____

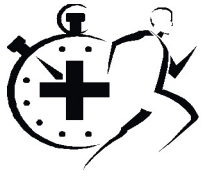
Insurance Information

Primary Insurance Carrier: _____
 Member ID: _____ Group Number: _____
 Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
 Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____
 Secondary Insurance Carrier: _____
 Member ID: _____ Group Number: _____
 Policy Holder's Name: _____ Policy Holder's Date of Birth: _____
 Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____

Please be advised that Orthopedics Today does not treat injuries acquired by an accident where a third party entity is held liable for the incident (i.e. auto insurance, homeowner's insurance, etc.). Orthopedics Today only files claims on personal insurance, worker's compensation, and accepts self-pay patients. Any appointment under other circumstances may be cancelled.

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: _____ **Date:** _____



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PLEASE FILL OUT COMPLETELY

Preferred Pharmacy: _____ Pharmacy Phone: _____

List of Medication and Dosage:

See list provided by patient

Have you had any past problems with anesthesia? Y N

If yes please explain:

Height: _____ Weight: _____

Chief Complaint

Reason for your visit today (Please specify Left and/or Right Side):

Symptoms Please Circle: Sharp Pain Dull Pain Numbness Tingling Stiffness Burning Sensation

Additional Symptoms Not Listed:

Date of Injury or when symptoms started: _____

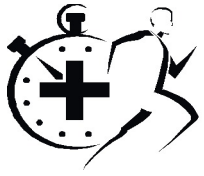
Describe how the injury or problem occurred: _____

What treatments have you already tried: _____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or guardian) Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____



ORTHOPEDICS TODAY

PLEASE FILL OUT COMPLETELY

Acknowledgement and Acceptance of Privacy Notice and Practices (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in the above paragraph:

No restrictions- may release information if requested to anyone

Restrictions: list who we may release information to regarding your healthcare

I wish to be contacted in the following manner (Check all that applies):

Home Phone: _____ Cell Phone: _____

O.K. to leave message with detailed information

Leave message with call back number only

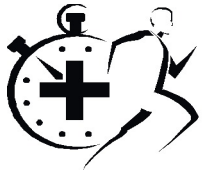
Work Phone: _____

O.K. to leave message with detailed information

Leave message with call back number only

Patient (or guardian) Signature: _____

Date: _____



ORTHOPEDICS TODAY

Office policies

Welcome to Orthopedics Today. We realize you have a choice for your medical care and we are pleased you have chosen us to provide your care. Please be advised that our office houses a physician, physician's assistant, and physical therapy center. As long as you sign in, our receptionist will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionist of any address changes, phone number changes, or change in insurance **before** you are seen. All charges will be submitted to your insurance company. Any remaining balance is the responsibility of the patient or their guardian.

Prescription Request

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill requests. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day.

Clinical Questions

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and may not be called away from patients to speak to you. Our receptionist will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Patient Forms

Please be aware that we charge \$20.00 to complete the following paperwork:

Insurance Forms

AFLAC

FMLA

Disability

We require 4-5 business days to complete any paperwork given.

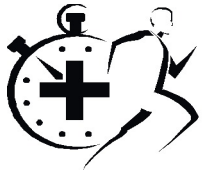
No Show Policy

Please be aware there will be a \$25.00 charge for any appointments that are missed, not cancelled, or rescheduled 24 hours prior to the appointment.

I have read and fully understand the above information.

Patient (or guardian) Signature: _____

Date: _____



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Privacy Notice & 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.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for audit purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions concerning your care. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Please let the front desk know if you would like a copy of this document.