



# ORTHOPEDECS TODAY

Today's Date: \_\_\_\_\_

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

Last

First

Middle Initial

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender: M F

Preferred Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Financial Responsible Party (if different than patient or if patient is a minor): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Ethnicity (Please Select One):**

- Hispanic or Latino
- Not Hispanic or Latino
- Decline

**Race (Please Select One):**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Decline

**Date of Injury** (if applicable): \_\_\_\_\_ **Will this injury be filed with Worker's Compensation?**  Yes  No

**Personal 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: \_\_\_\_\_

**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:** \_\_\_\_\_



# ORTHOPEDECS TODAY

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Are you currently taking any medications?  Yes  No  See list provided

**\*\*Please include all blood thinning medications and any prescribed weight loss pills on the list below.\*\***

Medication	Dose	Frequency

Have you had any past problems with anesthesia?  Yes  No If yes, please explain:

\_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### **Chief Complaint**

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

\_\_\_\_\_

Symptoms (Check all that apply):  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: \_\_\_\_\_

**Was this injury work-related?**  Yes  No **Was this injury due to an auto accident?**  Yes  No

**\*\*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 health insurance 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:** \_\_\_\_\_



# ORTHOPEDECS TODAY

## 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 a 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: Orthopedics Today may release information, if requested, to anyone.
- Restrictions: Please list who we may release information regarding your healthcare to below

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

Home/Cell ph#: \_\_\_\_\_

Work ph #: \_\_\_\_\_

- Leave message with detailed information
- Leave message with call back number only

- Leave message with detailed information
- Leave message with call back number only

### Office policies

Please be advised that our office houses physicians, physician's assistants, and a physical therapy center. After you sign in, our receptionists will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionists of any address, phone number or insurance change **before** you are seen. The office may verify insurance coverage prior to services being rendered, however, it is ultimately the patient's responsibility to be mindful of their own insurance benefits; including any required referrals or authorizations. All charges will be submitted to your insurance company. Any remaining balance is the responsibility of the patient or their financial responsible party.

### 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 receptionists will get your message to our clinical staff and they will return your call as soon as possible.

### Patient Forms

Please be aware that we charge \$20.00 to complete the paperwork for any of the following: FMLA, long term or short term disability, third-party insurance (i.e., AFLAC, Unum, etc.). We require 4 business days to complete paperwork.

### No Show Policy

Please be aware there will be a \$25.00 charge for any appointments that are missed or not cancelled 12 hours prior.

**I have read and fully understand the above information.**

**Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_**



# ORTHOPEDICS TODAY

## 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 auditing 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 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 practice manager. 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.*