PRECISION ORTHOPEDICS & SPORTS MEDICINE
NEW PATIENT PACKET

PATIENT DEMOGRAPHICS

NAME (LAST, FIRST, MI)	BIRTH DATE	SEX	AGE

STREET ADDRESS	CITY	STATE	ZIP

PRIMARY PHONE #	ALT PHONE #	EMAIL

SOCIAL SECURITY #	MARITAL STATUS (SINGLE, MARRIED, WIDOWED)	RACE/ETHNICITY	PREFERRED LANGUAGE

PRIMARY CARE PHYSICIAN	ADDRESS	PHONE #	FAX #

REFERRING PHYSICIAN (IF NOT PCP)	ADDRESS	PHONE #	FAX #

EMPLOYER INFORMATION

EMPLOYER NAME	ADDRESS	PHONE #

PRIMARY INSURANCE

INSURANCE NAME	SUBSCRIBER NAME	SUBSCRIBER'S DOB	RELATIONSHIP TO PATIENT

POLICY #	GROUP #	SPECIALIST COPAY AMOUNT	POLICY HOLDER EMPLOYER

SECONDARY INSURANCE

INSURANCE NAME	SUBSCRIBER NAME	SUBSCRIBER'S DOB	RELATIONSHIP TO PATIENT

POLICY #	GROUP #	SPECIALIST COPAY AMOUNT	POLICY HOLDER EMPLOYER

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EMERGENCY CONTACT (IF NONE PLEASE WRITE 911)

NAME:	PHONE #	RELATIONSHIP TO SELF:

PATIENT MEDICAL INFORMATION

HEIGHT:	WEIGHT:	PHARMACY NAME:	PHARMACY PHONE #:

CHIEF COMPLAINT/REASON FOR VISIT:	PART OF THE BODY: (UP TO 2 BODY PARTS CIRCLE R/L)	ONSET DATE OF SYMPTOMS/PAIN:
	☐ SHOULDER (R/L) ☐ ELBOW (R/L) ☐ WRIST (R/L) ☐ HAND (R/L) ☐ HIP (R/L) ☐ KNEE (R/L) ☐ ANKLE (R/L) ☐ FOOT (R/L) ☐ NECK (R/L) ☐ BACK (R/L)	_____/_____/_____

ARE YOUR INJURIES RELATED TO:	☐ AUTO ACCIDENT ☐ WORK ACCIDENT ☐ OTHER ACCIENT ☐ LIEN

DATE OF ACCIDENT:	CLAIM ADJUSTER/LAW OFFICE NAME:	CLAIM ADJUSTER/ LAW OFFICE ADDRESS:	CLAIM ADJUSTER/ LAW OFFICE PHONE:	CLAIM ADJUSTER/ LAW OFFICE FAX:
___/___/_____				

CLAIM NUMBER:	PATIENT'S CAR INSURANCE: (WRITE NAME AND PHONE NUMBER FOR CAR INSURANCE)

SOCIAL HISTORY: (CHECK ALL THAT APPLY)

DO YOU CURRENTLY SMOKE TOBACCO OF ANY KIND?	*IF YES, HOW OFTEN DO YOU SMOKE?*
	☐ CURRENT EVERYDAY SMOKER ☐ CURRENT OCCASIONAL SMOKER

ALCOHOL USE:

☐ YES

☐ NO

NUMBER OF DRINKS PER WEEK: _____

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MEDICAL HISTORY

☐ NO MEDICAL HISTORY IS KNOWN

PREVIOUS CONDITION WHICH YOU WERE DIAGNOSED WITH:

☐ EYE, EAR, NOSE & THROAT PROBLEM
☐ HEART DISEASE
☐ LUNG DISEASE
☐ KIDNEY/LIVER DISEASE
☐ STOMACH/INTESTINAL DISEASE
☐ BONE/JOINT/MUSCLE DISEASE
☐ DIABETES
☐ CANCER
☐ VASCULAR DISEASE
☐ PSYCHIATRIC PROBLEMS

SURGICAL HISTORY

PRIOR SURGERY DATES: **SURGERY DETAILS:**

☐ _____/_____/_____

☐ _____/_____/_____

☐ _____/_____/_____

FAMILY MEDICAL HISTORY

☐ NO FAMILY MEDICAL HISTORY IS KNOWN **DESCRIBE CONDITION:**
☐ FATHER
☐ MOTHER
☐ SIBLING
☐ SPOUSE
☐ CHILD
☐ OTHER

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ALLERGIES

LIST ANY KNOWN ALLERGIES YOU HAVE HAD TO ANY MEDICATIONS.

☐ NO ALLERGIES

☐ _____

☐ _____

☐ _____

☐ _____

MEDICATIONS

CURRENT MEDICATIONS, INCLUDING FREQUENCY AND DOSAGE IF KNOWN:

☐ NO CURRENT MEDICATIONS

☐ _____ FREQ:_____ DOSAGE:_____

☐ _____ FREQ:_____ DOSAGE:_____

☐ _____ FREQ:_____ DOSAGE:_____

☐ _____ FREQ:_____ DOSAGE:_____

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FINANCIAL POLICY

1. Thank you for choosing Precision Orthopedics and Sports Medicine for your healthcare needs. We are glad to bill your insurance carrier for the services you receive.
2. Please be aware, however, with the great number of insurance policies that cover our many patients, it is impossible for our staff to keep up with all the various insurance carrier's benefits related to the services you may receive.
3. We strongly encourage you to become familiar with your insurance benefits. We will make our best efforts to coordinate your benefits; however, our office cannot accept responsibility for lack of benefit coverage.
4. All insurance plans are billed as a courtesy, and we will provide your insurance carrier with all necessary information for claims processing. We will bill your insurance carrier up to two times per visit. We encourage you to retain the explanations of benefits your insurance carrier mails you to track the status of your account. <u>If your insurance carrier denies our claim due to lack of benefits, you are ultimately responsible in full for payment of the bill.</u>
5. Payment of specialist copays/deductible and any outstanding patient balances are expected at the time of service.
6. Late or no-show appointments may incur a cancellation fee if our office is not notified 24 hours prior to your appointment. As a courtesy to you, our office will make a confirmation call the day prior to your appointment.
7. If any disability or workers' compensation forms are needed to be completed by the physician or front office, there is a $15 form fee. Please allow the staff 5-7 business days to complete your forms.
8. Any Motor Vehicle Accident forms are a $10 charge. Please allow 3-5 business days to complete your forms.
9. If you want to request your medical records, a medical records release form must be signed. Precision charges 76 cents per page for all records. Please be advised there may be an additional fee for records, or a handling fee.

Thank you. Please sign to acknowledge your understanding of this agreement:

Date: _____ Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Precision Orthopedics & Sports Medicine
HIPAA Notice of Privacy 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 TI CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected heath information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved I your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose you protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in

sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when you physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers' Compensation, Inmates, Required Uses and disclosures, to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Use and Disclosures will be made only with your consent, authorization, or opportunity o object unless required by law.

You make revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this nose from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have you physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to chance the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice as published and becomes effective on/or before April 14th, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Donna Boatman in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

PATIENT SIGNATURE: _____ DATE: _____