

# 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	

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: (CIRCLE BELOW) <input type="checkbox"/> SHOULDER <input type="checkbox"/> ELBOW <input type="checkbox"/> WRIST <input type="checkbox"/> HAND <input type="checkbox"/> HIP <input type="checkbox"/> KNEE <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT <input type="checkbox"/> NECK <input type="checkbox"/> BACK	LEFT OR RIGHT SIDE:  <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT	ONSET DATE OF SYMPTOMS/PAIN:  ____/____/____  PRIOR IMAGING: Yes ____ No ____ X-Ray ____ MRI ____ Other _____	
ARE YOUR INJURIES RELATED TO:		<input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> WORK ACCIDENT <input type="checkbox"/> OTHER ACCIDENT <input type="checkbox"/> 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?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> CURRENT EVERYDAY SMOKER <input type="checkbox"/> CURRENT OCCASIONAL SMOKER		
ALCOHOL USE:		NUMBER OF DRINKS PER WEEK:		
<input type="checkbox"/> YES <input type="checkbox"/> NO		_____		

## MEDICAL HISTORY

NO MEDICAL HISTORY IS KNOWN

### PREVIOUS CONDITION WHICH YOU WERE DIAGNOSED WITH:

- EYE, EAR, NOSE & THROAT PROBLEM
- HEART DISEASE
- HIGH BLOOD PRESSURE
- LUNG DISEASE
- KIDNEY DISEASE
- LIVER DISEASE
- HIGH CHOLESTEROL
- REFLUX/HEARTBURN
- STOMACH/INTESTINAL DISEASE
- BONE/JOINT/MUSCLE DISEASE
- VASCULAR DISEASE
- DIABETES
- CANCER
- PSYCHIATRIC PROBLEMS

## SURGICAL HISTORY

### PRIOR SURGERY DATES:

### SURGERY DETAILS:

- \_\_\_/\_\_\_/\_\_\_
- \_\_\_/\_\_\_/\_\_\_
- \_\_\_/\_\_\_/\_\_\_

## FAMILY MEDICAL HISTORY

- NO FAMILY MEDICAL HISTORY IS KNOWN
- FATHER
- MOTHER
- SIBLING
- SPOUSE
- CHILD
- OTHER

### DESCRIBE CONDITION:

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

## 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. If your insurance carrier denies our claim due to lack of benefits, you are ultimately responsible in full for payment of the bill.
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 IT 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 health 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 in 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 your 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 to object unless required by law.

You may 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 see 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 notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your 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 change 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 was published and becomes effective on/or before April 14<sup>th</sup>, 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, Alexis Santander, 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: \_\_\_\_\_