PATIENT REGISTRATION FORM

Full Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security: _____-_____-_____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Email address: _____ Gender: ☐ Male ☐ Female

Is the patient in a Nursing Home/Skilled Nursing Facility? ☐ Yes ☐ No Name of Facility: _____

Is this visit related to: ☐ Personal Injury ☐ Work Related ☐ Auto ☐ Sports ☐ Chronic

**** If your visit today is related to a work or auto accident, please notify the front desk ****

Claim Number: _____ Date of Injury: _____

IF PATIENT IS UNDER 18

Who is responsible for the bill (Name): _____ DOB: _____

Relationship to patient: _____ Phone: _____ Cell: _____

Address: _____ Social Security #:_____

Employer: _____ Employer Phone: _____

Employer Address: _____

Patient's Employment Status: ☐ Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Patient's Employer: _____ Occupation: _____ Phone: _____

Employer Address: _____

Spouse/Additional Parent Name: _____ DOB: _____

Relationship to patient: _____ Phone: _____ Cell: _____

Address: _____ Social Security #:_____

Employer: _____ Employer Phone: _____

Employer Address: _____

Primary Insurance

Plan Name: _____

Policy #: _____Group #: _____

Subscriber Name: _____

DOB: _____ Employer: _____

Secondary Insurance

Plan Name: _____

Policy #: _____Group #: _____

Subscriber Name: _____

DOB: _____ Employer: _____

Who to call for an emergency: Name: _____

Phone Number: _____ Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Orthopaedics, PC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

ORTHOPAEDICS, P.C.

PATIENT HISTORY FORM

Patient name: _____ Todays Date: _____

Referring Doctor: _____ Family Doctor: _____

Which is your dominant hand? ☐ Right ☐ Left Height: _____ Weight: _____

Race: ☐ Asian ☐ Black ☐ Mexican American/Hispanic ☐ White ☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____ **Language**: ☐ English ☐ Other: _____

Chief Complaint

Why are you seeing the doctor today (please include side if applicable): _____

Have you been previously treated for this problem? ☐ Yes ☐ No If so, where? _____

Date of Injury/Onset of Problems: _____

Personal Past Medical History

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy Last Seizure _____	☐	☐	MRSA/Staph Infection
☐	☐	Arthritis	☐	☐	Heart disease/failure	☐	☐	Osteoporosis
☐	☐	Asthma/COPD	☐	☐	Hepatitis	☐	☐	Polio
☐	☐	Birth defects	☐	☐	HIV/AIDS	☐	☐	Psychological
☐	☐	Bladder problems	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Bleeding disorder	☐	☐	High Cholesterol	☐	☐	Sexually Transmitted Disease
☐	☐	Blood thinners	☐	☐	Kidney Problems	☐	☐	Stroke/TIA
☐	☐	Bowel Problems	☐	☐	Intestinal Disorder	☐	☐	Tuberculosis
☐	☐	Cancer type _____	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Diabetes Current A1C _____	☐	☐	Low Blood Pressure	☐	☐	Ulcer type _____
☐	☐	DVT/Blood clots	☐	☐	Lung Problems	☐	☐	Currently pregnant

Any additional medical problems we should be aware of: _____

Family History: *Have your mother, father, grandparents, or siblings ever been treated in the past or are currently being treated for any of the following?*

Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's	☐	☐	Heart Disease	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Kidney Disease	☐	☐	Other _____
☐	☐	Cancer	☐	☐	Osteoporosis			_____
☐	☐	Diabetes	☐	☐	Stroke			_____

Please list <u>health status</u> or <u>cause of death</u> for the following family members:

Mother: _____ Father: _____

Social History:

Marital Status: _____ Do you live alone? ☐ Yes ☐ No Do you have children? ☐ Yes ☐ No #_____

☐ Never a Smoker
☐ Former Smoker Year Started: _____ Year Stopped: _____
☐ Current Smoker Year Started: _____ # of packs daily: _____
Do you consume alcohol products? ☐ Yes ☐ No Amount and frequency: _____
Do you currently or have past illicit drug usage? ☐ Yes ☐ No Amount and frequency: _____

Surgical History:

Surgery/Hospitalization	Year	Any complications

Have you ever had any problems with anesthesia? ☐ Yes ☐ No If yes, elaborate: _____

Review of Systems:

GENERAL
- ☐ Fever
- ☐ Weight Change
- ☐ Hormonal Problems
- ☐ Other_____
- ☐ **NONE**

KIDNEY/BLADDER
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Incontinence
- ☐ Other_____
- ☐ **NONE**

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Wheezing
- ☐ Other_____
- ☐ **NONE**

EYES
- ☐ Glasses/Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other_____
- ☐ **NONE**

NEUROLOGICAL
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Other_____
- ☐ **NONE**

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Blood Problems
- ☐ Clotting Disorder
- ☐ Lymph problems
- ☐ Other_____
- ☐ **NONE**

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Diarrhea/Constipation
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Other_____
- ☐ **NONE**

EAR,NOSE,THROAT
- ☐ Difficulty Swallowing
- ☐ Ear Pain
- ☐ Seasonal Allergies
- ☐ Hard of Hearing
- ☐ Other_____
- ☐ **NONE**

CARDIOVASCULAR
- ☐ Chest Pain/Palpitations
- ☐ Fluid/Swelling
- ☐ Other_____
- ☐ **NONE**

SKIN
- ☐ Rashes/Eruptions
- ☐ Cyanosis/Jaundice
- ☐ Other_____
- ☐ **NONE**

PSYCHOLOGICAL
- ☐ Anxiety/Depression
- ☐ Mood Swings
- ☐ Other_____
- ☐ **NONE**

Allergies: *Please describe any current or past allergic reactions to medications*

Medication Name	Reactions (itching, cough, hives, etc)	How was/is reaction treated

☐ I DO NOT have any drug allergies

Medications: *Please list **all** medications you take with or without a prescription (use additional paper if needed)*

Medication Name	Dosage/# per day	Reason for taking

☐ I DO NOT take any medications ☐ Please see ATTACHED list

Current Pharmacy: _____ City: _____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

PATIENT REGISTRATION FORM
DISCLOSURE AND CONSENTS

Patient Name: _____ **Date of Birth**: _____
First Name M.I. Last Name

As required by the Health Insurance Portability and Accountability Act of 1996, Orthopaedics, PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information as describe in the above Notice.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize direct payment of my insurance benefits of Orthopaedics, PC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not eh services I am to receive are a covered benefit. I understand and agree that I will be responsible to any co-pay or balance due that Orthopaedics, PC is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/TRICARE INSURANCE BENEFITS
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of y or my dependent's authorized benefits be made directly to Orthopaedics, PC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Orthopaedics, PC Patient Information Privacy Policy. I hereby authorize Orthopaedics, PC or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

LAB/MRI/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, MRI, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Orthopaedics, PC or his or her designee.

FINANCIAL POLICY

MESSAGE TO OUR PATIENTS:
The following credit policies and instructions were made after careful deliberation and are necessary for good doctor-patient relationships. They must be followed by all patients if we are to continue to provide the medical care and service that you and your family want and need. All accounts not paid according to these polices will be considered delinquent and necessary action will have to be initiated. THE CLINIC DOES NOT HOLD ANOTHER PARTY RESPONSIBEL FOR PAYMENT OF SERVICE YOU RECEIVE. AT ALL TIMES THE AMOUNT DUE IS TH RESPONSIBILITY OF THE PATIENT. Please let us know if you have any questions regarding these polices of if any of these polices will create an undue hardship for you. There is a $25 charge on all returned check.

STATE OF CREDIT POLICY:
All accounts are due and payable within 30 days of first statement. A finance charge of 1% will be applied the 1st of each month to all accounts with unpaid balances over 30 days old. This applies to all accounts with unpaid balances.

NO INSURANCE
OFFICE CHARGES: due and payable at the time of service
HOSPITAL/OUTPATIENT CHARGES: 30 days open credit is extended to all patients with a good credit rating. The account is due in full at the end of this period unless authorization is received from our office to pay over a longer period of time. You may call or write for his permission. Upon request, special consideration may be extended in the event of prolonged illness, unemployment, or other unusual circumstance. To avoid misunderstandings, we invite you to discuss your circumstance early.

PERSONAL INSURANCE:
OFFICE CHARGES: We will be happy to submit the office charges to your personal insurance company. You are responsible to provide us with your insurance card with policy numbers and address of the insurance company. All office charges are due and payable within 30 days of billings.
HOSPITAL/OUTPATIENT CHARGES: Credit is extended to all patients with good credit rating. We cannot accept the responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim; in these situations, services are billed to you as the patient, and you will be held personally responsible for your account until the account is paid in full. As a courtesy, we will be happy to file the necessary insurance forms with your company; it is your responsibility to supply us with the insurance information and signed assignment of benefits. We expected payment within 30 days of filing insurance claim. If payment comes within the specified time and there is an insurance difference, you will be billed for that balance. If payment is delayed for any reason, we will look directly to you, the patient, for payment.

LIABILITY INSURANCE
If you are injured in an **automobile, motorcycle, or other personal injury accident**, the circumstances being such that you believe another party is responsible (**liability claim**), please remember that since you are the one receiving treatment, the clinic can only look to you for payment. It is our policy that payment for your treatment be on a current basis. At the time of the settlement of your claim, you will be **reimbursed** by your attorney or insurance company. We will **not** hold your account open during the period of litigation. We expect payment promptly.

MANAGED CARE INSURANCE
While we do participate in certain plans, insurance companies and employers **frequently change** networks and provider relationships. The PARTICIPATING PROVIDERS LIST you have may not be current. Please check with your insurance company to obtain your most current benefit information for services provided by our office.

WORKERS COMPENSTATION
If you on-the-job injury is verified as a Work's Compensation claim, we will bil your employer or insurance company. We attempt to preauthorize all work comp claims prior to the first appointment. If we are unable to obtain authorization and you do not bring written authorization with you the day of your first visit, your account will be treated as a self-pay and we will ask that you pay for the visit at the time of service. If you have questions about your worker's comp authorization, please call our office

MEDICARE
This office has voluntarily elected to participate with the Medicare Assignment Program. What this means to our patients is that we accept all responsibility of filing Medicare claims and payments are made directly to our office. If you do not carry supplemental insurance, after we receive the Medicare payment, you will be billed for the deductible and the 20% allowed by Medicare. Payment is due when billed.

MEDICARE AND SUPPLEMENTAL INSURANCE
If you do carry supplemental insurance, we will submit the claim as soon as the Medicare payment is received. You are responsible to pay the deductible and the 20% allowed by Medicare if your co-insurance does not pay within the limits of the credit policy.

MEDICARE AND WELFARE
Medicare and Welfare will be submitted automatically. You must bring your eligibility card with you at the time of the service. This card must verify that you effective for the month you are receiving treatment.

MEDICAID (TITLE XIX)
You must bring your eligibility card with you to each visit. The card must show that coverage is valid for the month you are being treated. If you do not present this card at the time of service, you will be expected to pay cash for that day's service. We participate with Iowa Welfare. Other out-of-state recipients will be responsible to pay their own account at the time of service.

SPECIAL COMMENTS
The following are special comments and instructions for those with insurance coverage of those of you involved in auto accidents, and/or 3rd party litigation. **Please read carefully.** If you have any questions, please ask our staff for immediate clarification.

1. Your insurance policy is a contract between you and your insurance company. Therefore, the Clinic cannot bill or charge your insurance company for services rendered to you, but can only submit a claim for the charges incurred.
2. We cannot guarantee to you that your insurance will pay your claim. It is very important that you will understand completely the provision of your insurance policy.
3. If your insurance company fails to pay your claim, they should explain to you why it was rejected. If you are dissatisfied with their rejections or the amount they pay, it is your responsibility to take the matter up directly with your insurance company. Please do not penalize the clinic or jeopardize your credit rating by not paying your bill because of this dissatisfaction.
4. If you have ever had an account from this office turned over to a collection agency or involved in a bankruptcy case, we must insist on cast payment at the time of service without exception.

Please feel free to speak with a member of our staff or be directed to the practice administrator with any questions. We would be happy to help you. By signing this form, I agree that I have read and understand the above information and all my questions have been answered by a staff member of Orthopaedics, PC.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
(IF DIFFERENT FROM PATIENT)

GUARANTOR NAME (Please print): _____