Orthopaedic Specialists, P.L.L.C.
PATIENT INFORMATION

Date: _____

Patient's Last Name	First	Middle Initial	Best contact number
Street Address	**City and State**	**Zip Code**	**Secondary number**

Social Security No.	DOB	Age	Sex		Marital Status					E-mail Address:
			M	F	S	M	W	D	P	

Are You Here Due to an Injury?_____ If Yes, what type: Auto Work Other

Date of Injury or Accident: _____

If Injury or Accident will you be filing car insurance, workers compensation, or liability insurance: Yes or No

Emergency contact

Name_____ Relationship to Patient_____ Phone number_____

INSURANCE INFORMATION

IMPORTANT: INSURANCE INFORMATION MUST BE FILLED OUT COMPLETELY IN ORDER TO FILE A CLAIM

Primary Insurance Co. Name		Secondary Insurance Co. Name	
Group # ID#		Group # ID#	
Name of Responsible Party for bill	Amount of Co-pay, if applicable $	Effective Date of Coverage	Amount of Co-pay, if applicable $
Name of Policyholder: If the same as patient check here ☐		Name of Policyholder: If the same as patient check here ☐	
Address and Phone Number of Policyholder		Address and Phone Number of Policyholder	
Policyholder Home Phone No. Work Phone No.		Policyholder Home Phone No. Work Phone No.	
Policyholder DOB Sex		Policyholder DOB Sex	

INSURANCE AUTHORIZATION, ASSIGNMENT and CONSENT TO TREAT

If you, your family member or friend wish to audio or video record any employee, including our medical providers, written consent must be obtained by the employee and Dr. Grossfeld. If you are identified as having recorded in any manner and have failed to obtain authorization, immediate action will be taken to discharge you from Orthopaedic Specialists, PLLC.

I hereby authorize Orthopaedic Specialists, P.L.L.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance

Signature of Patient or Parent/Guardian (if minor) _____

Date: _____

ORTHOPAEDIC SPECIALISTS, PLLC

Financial Policy for Patient Care Services

To help provide the most efficient and reasonable health care service, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have **accurate** and **complete** information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days.

If you have insurance and we file with your carrier, we require payment of balances which are deemed your responsibility (copayments, deductibles, co-insurance) at the time the service is received. We ask that you please contact your insurance company if your claim has not been paid within 30 days.

Patient "no shows" and cancellations are a tremendous loss for a practice. Please help our office reduce losses by canceling with at least a 48 hour notice. ***Failure to show up for your scheduled appointment may result in a $50.00 fee to be paid by the patient***.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a "Self Pay" patient, or for the amount of any deductible, copayments or coinsurance. If you are unable to meet your financial obligation, you may be asked to reschedule. If you are a "Self Pay" patient, please see the receptionist for an additional "self-pay" policy.
3. Please be prepared to present your insurance card to the receptionist upon signing in. If you cannot provide a copy of your insurance card, you will be considered "Self Pay" and will be required to pay for services in full on the date they are received. Upon receipt of insurance information, and in the event your insurance pays your claim, you will be refunded the amount of the credit due to you at that time.
4. Understand that we, from time to time, may verify insurance benefits on your behalf. Please be aware that we cannot be responsible for misinformation received from your insurance company. Insurance companies have a disclaimer for all callers stating that the benefits given over the phone are only an estimate and that the benefits are not determined until the actual claim is paid. Therefore, it is not possible for us to guarantee any type of coverage or benefit on your behalf.
5. Further understand that there is a charge of $35.00 for each disability or FMLA form that is completed on your behalf.
6. Should your check be returned for insufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees as permitted by state law. The use of a check is your acknowledgement and acceptance of this policy and its terms and conditions.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Orthopaedic Specialists uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive. Orthopaedic Specialists will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. Orthopaedic Specialists prohibits the sale and/or use of Protected Health Information for marketing or fundraising purposes without the patient's written authorization. This does not include disclosure for payment or treatment nor for disclosure to patients or their designees in exchange for a reasonable cost-based fee.

Orthopaedic Specialists may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

In the event a patients Protected Health Information is breached, patient will be notified via certified mail.

At the patient's request, physician will not disclose information to health plans about care the patient has paid out-of pocket for, unless the disclosure is required by law.

Orthopaedic Specialists may disclose information to a deceased patient's family and friends as permitted when the patient was alive; that is when these individuals were involved in providing care or payment for care.

Orthopaedic Specialists will have 30 days to respond to request for medical records with one 30-day extension, regardless of where records are kept. Physician must provide access to EHR and other electronic records in electronic form and format requested by the individual if the records are "readily reproducible" in that format. Paper copies are permitted in the absence of readily producible e-formats.

Orthopaedic Specialists may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records

Orthopaedic Specialists must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint. If you have any questions or complaints, please contact the Privacy Officer at (502) 212-2663.

I have reviewed my rights and been given the opportunity to ask questions.

I,_____, understand that in the case that I may need someone other than myself to obtain medical information (medical records, prescriptions, or phone calls for examples) for me from the office, their names needs to be listed BELOW.

_____ _____ Name of authorized person(s)

Name of authorized person(s)

_____ _____

Patient Signature or authorized representative Date

_____

Printed name if signed on behalf of patient (parent, legal guardian, personal representative, etc.)

Consent for Release of Prescription History

This is for your safety!!! Dr. Grossfeld is requesting information to access your prescription information because this is the MOST accurate and efficient way to place your medication list in your electronic health record. This can help PREVENT dangerous drug interactions, duplication of similar medications and allergic reactions. It is very important that she have a complete list of all your medications and doses. Accessing the prescription history is going to make this process accurate and safe.

I authorize Orthopaedic Specialists PLLC, to access my prescription history from unaffiliated medical providers, insurance companies, and pharmacy benefit managers, to help keep my medical records as complete as possible. I understand that my prescription history from other sources may be viewed by the providers and staff within Orthopaedic Specialists PLLC, and may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____

Printed Name

_____ _____

Patient Signature Date

Photograph and Publicity Release Form

Occasionally, Dr. Grossfeld finds different x-rays and images interesting and would like to share them for educational purposes.

I, _____, give my permission to use my image and/or appearance that may be embodied in any pictures, photos or x-rays. I understand that my name, medical record number, date of birth or any identifying factors will NOT be disclosed. I agree that Orthopaedic Specialists PLLC has complete ownership of such pictures, etc., including the entire copyright and may use them for any purpose consistent with Orthopaedic Specialists PLLC. These uses include but are not limited to illustrations, exhibitions, videotapes, reprints, reproductions, publications, advertisements and any promotional or educational materials in any medium now known or later developed, including the internet. I acknowledge that I will not receive any compensation or etc. for the use of such pictures, etc. and hereby release permission to Orthopaedic Specialists PLLC.

I have read and understand this consent and release.

I give my consent to Orthopaedic Specialists to use my images and likeness.

_____ _____

Signature (Parent/Legal Guardian if under age 18) Date

History and Physical
New Patient or Established Patient updated yearly
Orthopaedic Specialists Dr. Stacie Grossfeld

1. Name _____ Date: _____

2. How did you hear about our office? _____

I was referred by a patient / I am a prior patient (year treated _____)

3. Who is your primary care physician? _____

4. Occupation/Employer _____

5. Age_____ Weight_____Height_____BP_____ Pulse____Res. _____Right or Left Handed _____
Office staff will obtain

6. Reason for Consultation with Dr. Grossfeld _____
_____

7. Where is the pain located (If appropriate please indicate right or left side)? _____

8. What is the mechanism of injury that started your symptoms or was there an injury? If injury - Please describe. _____

9. **Date of injury OR when did your symptoms begin? (How long has your pain been present?)**
_____

10. **What is the quality of the pain? sharp / dull / throbbing?**

11. **Rate your pain on the VAS pain scale: Zero is no pain and 10 is the worst pain you have ever experienced Pain TODAY:** 0 -----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Worst the pain has EVER been: 0 -----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

12. **Have your symptoms limited your activities, if so how? _____**
_____

13. What is your present treatment for this problem? _____
_____

14. What is the past treatment for your symptoms? _____
_____

15. Please list medications taken for this problem (example: Aleve, Mobic, etc.) _____
_____

16. Have you had an *XRAY* for this problem in the last 6 months? If yes, when and where? Yes / No
_____

17. Have you had an *MRI* for this problem, if yes, location and date? YES / NO
_____

Please circle yes or no.

Family History

Yes No Osteoarthritis
If yes, list family member _____

Past PERSONAL History

Yes No High blood pressure	Yes No High blood pressure
Yes No Heart Condition	Yes No Heart Condition
Yes No Gout	Yes No Gout
Yes No Hyperthyroidism	Yes No Hyperthyroidism
Yes No Diabetes	Yes No Diabetes
Yes No Emphysema	Yes No Emphysema
Yes No Hypothyroidism	Yes No Hypothyroidism
Yes No Cancer	Yes No Cancer
Please list type _____	Please list type _____
Yes No Stroke	Yes No Stroke
Yes No Congestive Heart Failure	Yes No Congestive Heart Failure
Yes No Blood Clots	Yes No Blood Clots
Yes No Pulmonary Embolus	Yes No Pulmonary Embolus

HIV Positive? Yes No
Hepatitis C Positive? Yes No

Please list types of surgeries and dates performed:

_____

_____

Social History

Marital Status: □Single □ Married □ Divorced □ Widowed □ Partner
Do you have children? □ No □Yes How many? _____
Do you live alone? □Yes □ No Who lives with you? _____

Do you smoke?
□ Yes, I've smoked_____ packs of cigarettes per day for _____ years
□ No, I have never smoked
□No, I quit _____ years ago. At that time I was smoking _____ packs per day for ____years

Do you drink alcohol?
□ No, never (or rarely)
□ No, but I used to
□ Yes □Daily □ 1 or more times per week □ 1 or more times per month

Name_____ **DOB** _____

All information to be completed by patient

Constitutional:

No Yes Dizziness
No Yes Fever
No Yes Night sweats

Eyes:

No Yes Visual disturbance

Ears/Nose/Throat/Neck:

No Yes Hearing loss
No Yes Nosebleeds
No Yes Sinus problems

Cardiovascular:

No Yes Chest pain
No Yes Palpitations
No Yes Chest pressure

Respiratory:

No Yes Emphysema
No Yes Apneic episodes
No Yes Shortness of breath

Gastrointestinal:

No Yes Rectal bleeding
No Yes Heartburn
No Yes Abdominal pain

Genitourinary/Nephrology:

No Yes Blood in urine
No Yes Urinary difficulties

Musculoskeletal:

No Yes Back pain
No Yes Muscle weakness
No Yes Joint pain

Dermatologic:

No Yes Keloids/hypertrophic scars
No Yes Skin rash
No Yes Ulcerations

Neurologic:

No Yes Impaired balance
No Yes Seizure

Psychiatric:

No Yes Addiction to alcohol
No Yes Addiction to medication
No Yes Depression
No Yes Anxiety

Endocrine:

No Yes Menstrual cycle irregularity
No Yes Perimenopausal symptoms

Hematologic/Lymphatic:

No Yes Prolonged bleeding
No Yes Blood clotting problem
No Yes Easy bruising

Allergy/Immunology:

No Yes Hives
No Yes Eyelid swelling

Dr. Stacie Grossfeld M.D/Angel Porter PA-C _____

Medication List

Allergies to Medications	**If no allergies please list "None"**		

Medication ****Including Vitamins and Herbs****	Dosage	Frequency/Number of times per day	What is it for?

Updated 10-19-18