ORTHOPEDIC INSTITUTE

NP☐ EP☐

Name (First & Last): _____ **Date of Birth:** _____

Reason for Visit: _____

Body Part: _____ Side: L R When did your pain start? _____ Severity: 1 2 3 4 5 6 7 8 9 10

Does anything make your pain better? _____ Does anything make your pain worse? _____

Other Symptoms: Numbness Tingling Bruising Night Pains Other: _____

Have you tried Chiropractor care? Yes No If yes, where: _____ How long: _____

Have you tried previous Physical Therapy? Yes No If yes, where: _____ How long: _____

Have you had previous injections for this problem? Yes No If yes, what kind of injection? _____

Have you had X-rays: Yes No Date & Location: _____

Have you had an MRI: Yes No Date & Location: _____

Other imaging: Yes No Date & Location: _____

Occupation: _____

Preferred Pharmacy: _____ City: _____ State: _____

Primary Care Provider: _____ City: _____ State: _____

Allergies: _____

Medical History	Yes	No		Yes	No		Yes	No
Acid Reflux (GERD)			Gastrointestinal Disease			Osteomyelitis (bone infection)		
Anemia			Gout			Osteoporosis		
Anesthesia Complications			Heart Arrhythmia			Ostomy		
Anxiety			Heart Attack (MI)			Other		
Arthritis			Heart Problems			Pacemaker		
Asthma			Hepatitis			Peripheral Vascular Disease		
Autoimmune Disease			Hernia			Pneumonia		
Bleeding Disorder			Hypertension			Polio		
Blood Transfusions			Kidney Disease			Psoriatic Arthritis		
COPD			Kidney or Bladder Problems			Rheumatic Fever		
Cancer			Liver Disease			Rheumatoid Arthritis		
Congestive Heart Failure (CHF)			Lung Disease			Scarlet Fever		
Coronary Artery Disease (CAD)			MRSA			Spinal Disk Problem		
Defibrillator			Malignant Hyperthermia			Stroke		
Depression			Migraines			Thyroid Disease		
Diabetes			Multiple Sclerosis			Tuberculosis		
Emphysema			Muscle, Joint, or Bone Problems			Ulcers		
Epilepsy/Seizures			Nerve Compression/Irritation			Vascular Disease		
Fibromyalgia			Neurologic Disorder					
Fracture			Neuropathy					

Surgical History:

Previous Surgery: _____ Date: _____

Previous Surgery: _____ Date: _____

Previous Surgery: _____ Date: _____

Patient Name: _____

Date of Birth: _____

Acknowledgment of Receipt of Notice of Privacy Practices

- I acknowledge that I have been offered a copy or have received a copy of the "Notice of Privacy Practices" for Orthopedic Institute.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

By signing below, I am acknowledging that:
I am either the patient or the patient's personal representative;

_____ _____

Signature of patient or representative authorized by law Date

_____ _____

Print name Relationship to patient

Patient Name: _____

Date of Birth: _____

Authorization for Release of Health Information

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

1. Orthopedic Institute uses SureScripts. Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Orthopedic Institute
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Orthopedic Institute.
3. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
4. This authorization does not authorize Orthopedic Institute to discuss my health information or medical care with anyone other than those permitted under applicable law.
5. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a write to have a copy of this authorization.
6. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

_____ _____

Signature of patient or representative authorized by law Date

_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

_____

Relationship to patient

ORTHOPEDIC INSTITUTE

Patient Name: _____

Date of Birth: _____

Release of Billing Information

I hereby authorize Orthopedic Institute, and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and when identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I authorize Orthopedic Institute, to release any and all information necessary to adjudicate my claim with my insurance company (or companies).

_____ _____

Signature of patient or representative authorized by law Date

_____ _____

Print name Relationship to patient

ORTHOPEDIC INSTITUTE

Patient Name: _____

Date of Birth: _____

Statement of Financial Responsibility

It is the policy of the Orthopedic Institute to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. It is the patient's responsibility to provide us with current insurance information and to bring his or her insurance card to each visit. For patients who are beneficiaries of one of these insurance companies, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient before leaving the office.

- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; *however, a deposit of $100 is expected at the time of service before services being rendered.* Cost-sharing plans are not considered insurance and will be treated as self-pay.

- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of the visit. Payments for medical services not covered by an individual insurance plan are the patient's responsibility and is expected to be paid when billed.

- Orthopedic Institute offers special pricing for anyone if you do not have insurance. A deposit of $100 is expected before services being rendered.

- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice before the visit. Visits may be rescheduled, or the patient may be financially responsible due to a lack of referral.

- Patients scheduling an independent medical examination (IME) visits are expected to pay a deposit of $300 before that visit can be scheduled. Likewise, patients requesting an impairment rating (IR) visits are expected to pay a deposit of $100 before that visit can be scheduled. If the visit is not paid by an insurance company, the patient is expected to pay the amount in full before scheduling the visit. Preparation for these exams takes time and significant resources. If the patient no-shows for the visit or fails to cancel within 30 days for an IME or 48 hours for an IR, then the deposit will not be returned.

- Our staff is happy to help with insurance questions relating to your account. Specific coverage issues can only be addressed by the insurance company member service department.

- Minor patients will be expected to pay for services when unaccompanied by an adult. Copayments or self-pay deposits will be expected at the time of service. Services or non-emergent treatment will be denied if payment is not made at the time of service. Payments may be made in advance by phone, through our patient portal or during the self-check-in process.

- As a patient, I have given or will give Orthopedic Institute my home phone number, mobile phone number, email address, and/or other contact information. By signing below, I agree to be contacted by Orthopedic Institute, its affiliates, and/or a company hired by them using automatic dialing systems, recorded or artificial voice messages, text messages, emails, and/or similar methods. The purpose of these messages may include appointment reminders, patient feedback, surveys, marketing or promotional messages, upcoming events, unpaid balance messages, and/or other business messages.

Our practice firmly believes that a good physician-patient relationship is based on understanding and good communications. Questions about financial arrangements should be directed to the billing department. We are here to help you.

- **I agree to Orthopedic Institute's Financial Policy**

Assignment of Benefits

- I hereby authorize Orthopedic Institute to file claims on my behalf to my insurance company (or companies).
- I hereby agree that payment from my insurance company (or companies) is to be made directly to Orthopedic Institute.

_____ _____

Signature of patient or representative authorized by law Date

_____ _____

Print Name Relationship to patient