PowellOrthopedics
Knee & Shoulder / Sports Medicine

Patient Information Form

Chart #_____

Patient Name_____ Email_____

Address_____

_____

Home Phone_____ Cell_____ Work_____

DOB_____ SSN_____ Male_____ Female _____

Employer_____ Primary. Ins. Carrier_____

Member ID_____ Group_____

Secondary. Ins. Carrier_____

Member ID_____

Please fill out the name of the primary cardholder of your insurance if it is different from the patient above.

Name_____ DOB_____

SSN_____ Male _____ Female_____

Employer_____ Work #_____

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____, hereby authorize the physician and staff of Powell Orthopedics, P.A., to contact in case of emergency, or to discuss any information about health, wellbeing, or appointments concerning the patient, with myself or spouse or with the following person or people.

1. Name_____Phone_____ Relation_____
2. Name_____Phone_____Relation_____

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any information needed. I also agree to an automated telephone system to call and remind me of a scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party player, hospital or physician any and all prescriptions, treatment, x-rays, and all other requested information or documentation pertaining shall be considered valid and effective as the original.

X_____Date_____

Patient/Guardian Signature

Mark. W. Powell, M.D. Orthopedic Surgery / 1450 E. Zion Rd, Suite 10 / Fayetteville, AR 72703
P: (479) 582-4647 Fax: (479) 582-4660 / www.powellorthopedics.com
Mailing Address: P.O. Box 9688 Fayetteville, AR 72703

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New Patient Information

Date:_____

Patient Name_____DOB_____Age:_____

Email:_____Chart #_____

Referring Physician_____ M_____ F_____ Dominant Hand: R L Both

PLEASE TELL US ABOUT YOUR ORTHOPEDIC PROBLEM: Height:_____ Weight:_____

When did it begin?_____ What caused it?_____

Previous Treatment? Yes No By whom?_____When?_____

PAST MEDICAL HISTORY: (circle all that apply)

Heart disease Heart attack Congestive Heart Failure High Blood Pressure Stroke

Lung Disease COPD Emphysema Bleeding disorder Blood Clots Pulmonary Embolus

Kidney Disease Liver Disease Diabetes Seizure Disorder Cancer-Type:_____

Other health problems:_____

_____

_____

PAST SURGICAL HISTORY: (please list)

1._____**Dr.**_____**Date:**_____

2._____**Dr.**_____**Date:**_____

3._____**Dr.**_____**Date:**_____

4._____**Dr.**_____**Date:**_____

5._____**Dr.**_____**Date:**_____

6._____**Dr.**_____**Date:**_____

7._____**Dr.**_____**Date:**_____

8._____**Dr.**_____**Date:**_____

LEGAL

Problem due to an accident? Yes No Is it litigation planned? Yes No

Auto Accident? Yes No Attorney's Name_____

Do you have an attorney? Yes No Address/Phone_____

PERSONAL AND FAMILY

Do you use tobacco? Yes No Amt. per day?_____Since?_____

Do you use alcohol? Yes No Amt. per day?_____Since?_____

Most physically demanding regular activity?_____ How often?_____

Occupation_____ Time at present Employer?_____ Previous?_____

Marital Status: Single Married Divorced Widowed

Living Status: Alone Spouse Children Parents Friend(s)

Family Health (List health problems, if deceased, please note age of death)

Father_____ Mother_____

Siblings_____ Children_____

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NAME:_____DATE:_____CHART#_____

MEDICINES:(prescription and non) (please list)

I take no medications:_____

1._____ _____mg 1 2 3 4 times a day

2._____ _____mg 1 2 3 4 times a day

3._____ _____mg 1 2 3 4 times a day

4._____ _____mg 1 2 3 4 times a day

5._____ _____mg 1 2 3 4 times a day

6._____ _____mg 1 2 3 4 times a day

7._____ _____mg 1 2 3 4 times a day

8._____ _____mg 1 2 3 4 times a day

9._____ _____mg 1 2 3 4 times a day

10._____ _____mg 1 2 3 4 times a day

11._____ _____mg 1 2 3 4 times a day

12._____ _____mg 1 2 3 4 times a day

13._____ _____mg 1 2 3 4 times a day

14._____ _____mg 1 2 3 4 times a day

15._____ _____mg 1 2 3 4 times a day

ALLERGIES (prescription and non)

_____

_____

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Have you recently experienced any of the following?- Check if "yes".

HEENT

_____ Eye pain or glaucoma
_____Require glasses
_____Visual impairment not corrected by glasses
_____Cataracs
____Trouble Hearing
_____Ringing of Ears
_____Repeated nose bleeds
_____Trouble breathing through nose
_____Difficulty swallowing
_____Hoarseness
_____Other difficulty speaking
_____Salivary gland problem

Cardiopulmonary

_____Cough
_____Coughing up phlegm
_____Coughing up blood
_____Pneumonia
_____Collapsed Lung
_____Tuberculosis
_____Asthma

_____Hay fever
_____Shortness of breath
_____Shortness of breath walking
_____Shortness of breath lying down
_____Chest Pain
_____Heart Attack
_____Dizziness
_____Loss of consciousness
_____Rapid heart beat
_____Irregular heart beat
_____Rheumatic fever
_____Blood clot in legs
_____Phlebitis
_____Pain in legs with walking
_____Painful whitening of fingers

GI

_____Abdominal Pain
_____Indigestion, heartburn
_____Nausea
_____Vomiting
_____Diarrhea
_____Constipation
_____Black Stools
_____Blood in stools
_____Loss of appetite
_____Ulcers
_____Hiatal hernia
_____Other hernia
_____Jaundice
_____Hepatitis
_____Gallstones
_____Colitis or enteritis
_____Cirrhosis
_____Pancreatitis
_____Loss of coordination
_____Tremor, shaking
_____Confusion

_____Spells
_____Seizures
_____Stroke
_____Traumatic Brain Injury
_____Gonorrhea
_____Other venereal disease
_____Trouble starting urination
_____Bladder not emptying
_____Decreased urinary stream

For Men

_____Discharge from penis
_____Difficulty with erection
_____Prostatitis
_____Enlarged prostate
_____Decreased sex drive

GU

_____Urinary tract infection
_____Burning with urination
_____Dark or bloody urine
_____Kidney Stones
_____Syphillis
_____Gonorrhea
_____Other venereal disease
_____Trouble Starting Urination
_____Bladder not emptying
_____Decreased urinary stream
_____ Leaking Urine

Neuro	**Patient Initials**	**Date**
_____Headaches	_____	_____
_____Back Pain	_____	_____
_____Neck Pain	_____	_____
_____Weakness	_____	_____
_____Numbness	_____	_____
	_____	_____
Other	_____	_____
_____Weight loss	_____	_____
_____Weight gain	_____	_____
_____Joint stiffness	_____	_____
_____Joint pain	_____	_____
_____Joint swelling	_____	_____
_____Poor sleeping	_____	_____
_____Depression	_____	_____
_____Anxiety	_____	_____
_____Crying spells	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

For Women

_____Birth control pills/shots/implants?
_____Date of last menstrual period
_____Are you pregnant?
_____Pain or other problems with intercourse
_____Decreased sex drive

PLEASE READ: The patient is responsible for all fees, regardless of insurance coverage. PAYMENT IS REQUESTED AT TIME OF SERVICE. A photocopy of this authorization shall have the same effect as the original.

X_____ Date_____

Patient/Guardian Signature

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PAYMENT POLICY

CO PAYS & CO INSURANCE: Your copay or deductible/co-insurance (whichever applies) is due at the time of your office visit. Please understand that some co-pays only pay for the office visit and other services such as x-rays, injections, etc. may apply to your deductible/co-insurance.We contact your insurance to get an explanation of benefits, however, the information we are given is not always accurate. You may want to call your insurance to confirm your benefits. After filing your claims sometimes, we are informed by your insurance that you may owe more than what was collected at time of your visit. If this is the case, we will send you a statement for the balance due.

SELF PAY: If you are not using insurance, full payment is due the same day as your visit.

LIABILITY OR 3RD PARTY INSURANCE: We do not file 3rd party insurance. If your primary insurance will not pay due to an accident of any kind, you are responsible for the bill in full at time of service.

SCHOOL INSURANCE: We accept school insurance. We will not file school insurance unless we have the filled out and signed documents on the day of the visit and only up to 4 days after the visit, IF we do not get these insurance documents from you in the allotted time, you will be responsible for filing it. Please understand, most school insurance does not pay the full amount of medical services, we must have the PCP referral on or before the day of your visit.

MEDICAID & AR KIDS PLANS OR INSURANCE REQUIRING A REFERRAL: Getting a referral is patient responsibility. IF a primary care referral is required, we must have the PCP referral on or the day before the day of your visit.

PAYMENT PLAN: We offer CARECREDIT, 6 MONTHS, 0 PERCENT PAYMENT PLANS for all balances over $200.00. CareCredit can also be used for balances under $200.00 but there is no discount and interest is charged by CareCredit. If you would like to qualify for a CareCredit card please call 1-800-365-8295 or contact them online.

PAYMENT OF ANY BALANCE DUE/COLLECTIONS: If you receive a bill please pay as indicated on the statement to avoid collections. All billing for Dr. Powell and physical therapy is filed and sent out by a 3rd party for us. Not paying your bill when due and not calling Powell Orthopedics, P.A. to discuss this matter can result in your account being sent to collections. Please understand we do not want to send our patients to collections but unfortunately, we have to do this sometimes. If we send your account to collections, we will never see you again as a patient and this may go against your credit rating.

MESSAGES LEFT ON YOUR PHONE REGARDING INSURANCE, BALANCE, OR SCHEDULED APPOINTMENTS: Sometimes we need to call patients/responsible party and discuss insurance requests or balance due and we get a voicemail. We also have an automated message that may call to inform you of your appointment or we may need to reschedule your appointment. If this happens, we would like your permission to leave you a voice message about this matter to inform you of what is going on. Please sign and print your phone number so we may leave you a message.

X_____ DOB_____ Phone #_____

Signature of Patient/Guardian

I HAVE READ AND UNDERSTAND AND WILL ABIDE BY THIS POLICY.

Print Full Name:_____

Signature_____SSN_____Date_____

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PT CLINIC WAIVER

Welcome to Powell Orthopedics! We are happy that you have chosen us for your rehabilitation needs. We will do everything in our power to make your physical therapy experience a positive one. Please take a few moments to review some information about our clinic.

Powell Orthopedics is a physician-owned facility, and as a patient, you have the right to choose your own physical therapy provider. We feel that our team-based approach to rehabilitation involving physicians, nurses and physical therapists provides the highest quality of care. However, you are free to pursue your rehabilitation at a clinic of your choosing.

In order to more effectively treat our patients, we have implemented the following clinical guidelines:

1) Appointment Times- Please try to arrive several minutes prior to your scheduled appointment time. We reserve the right to reschedule your appointment if you are more than 20 minutes late.
2) Cancellations- Please notify us in advance if you know you can't make an appointment. We realize situations arise that necessitate cancellations. We would just like to know as soon as possible so that we can schedule other patients.
3) No Shows- We reserve the right to discharge patients from physical therapy if that patient fails to show for 3 scheduled appointments without notification.
4) Children- We recognize that there are times when patients must bring young children to treatment sessions with them. Please note that we have a number of equipment pieces that can seriously injure a small child. Additionally, with the number of patients that are usually in the clinic, our therapists and other staff members aren't generally able to oversee your children. Please remember that your children are your responsibility.

Again, welcome to our clinic and we look forward to serving your rehabilitation needs! If you have any questions or concerns regarding your treatment, please bring them to our attention.

I have read the above information and I understand that Powell Orthopedics is a physician-owned facility, and that I have the right to attend physical therapy at any clinic I choose. Furthermore, I understand the clinical guidelines set forth above and I agree to adhere to them.

_____ _____

Signature Date

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