Name:
DOB:
Chart:
Age:
Date: Doctor:

Pennsylvania Orthopedic Associates, Inc.
Clinical Information

Patient Name _____

Chief Complaint _____

How did injury occur: _____

_____

Date of injury _____ Place of injury _____

Was injury work related? Yes No Auto related? Yes No
If so, when and where? _____

Have x-rays and/or MRIs been taken? Yes No If so, when and where? _____

Are you out of work due to this condition? Yes No If so, since when? _____

Do you smoke? Yes No Cigarettes _____ Pipe _____ Cigar _____

How long have you smoked? _____ How much do you smoke? _____

Do you drink alcohol? Yes No How much? _____

Height: _____ Weight: _____ Hand Dominance: Right or Left

Past surgeries? _____

Current medical problems? _____

_____

Current medications? _____

_____

Drug Allergies? _____

List all herbal/supplements you are currently taking. _____

Do you have a family history of Cancer, Diabetes, Lung Disease, Osteoporosis or Other Diseases?

_____

Name:
DOB:
Chart:
Age:
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Pennsylvania Orthopedic Associates, Inc.
Clinical Information

Patient Name _____

What number on a 0 to 10 scale would you give your average pain?

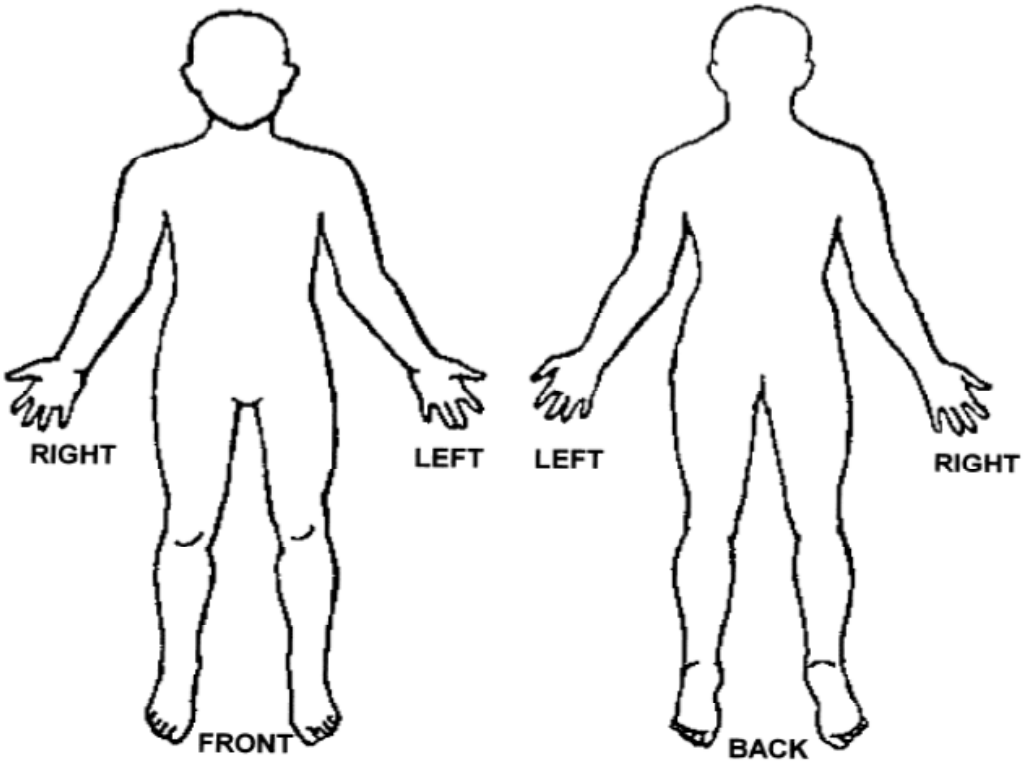
0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild pain			Moderate Pain			Severe Pain		

What number on a 0 to 10 scale would you give your pain when it is the worst?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild pain			Moderate Pain			Severe Pain		

Please note on the diagram where your pain is located. Please use the scale to note which sensations you are feeling.

/// Stabbing
xxx Burning
+++ Aching
=== Numbness
ooo Pins and Needles



Patient Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date: Doctor:

REVIEW OF SYSTEMS

CONSTITUTIONAL SYSTEMS		
Appetite change	Y	N
Chills	Y	N
Fever	Y	N
Headache	Y	N
Weight loss	Y	N
EYES		
Blurred vision	Y	N
Eye Pain	Y	N
Glasses/Contacts	Y	N
EARS, NOSE, THROAT		
Sinus congestion	Y	N
Sore throat	Y	N
Ringing Ear(s)	Y	N
Hearing loss	Y	N
RESPIRATORY		
Asthma	Y	N
Chronic cough	Y	N
Emphysema/bronchitis	Y	N
Shortness of breath	Y	N
Coughing up blood	Y	N
CARDIOVASCULAR		
Angina	Y	N
Arrhythmia	Y	N
Chest pain	Y	N
Heart attack	Y	N
High blood pressure	Y	N
GASTROINTESTINAL		
Abdominal pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Heartburn	Y	N
Nausea/vomiting	Y	N
Black stool	Y	N
SKIN		
Persistent itching	Y	N
Unusual lesions	Y	N
Rash	Y	N

	GENITOURINARY		
	Blood in urine	Y	N
	Frequent urination	Y	N
	Painful urination	Y	N
	Urgency	Y	N
	Bladder not emptying	Y	N
	Straining to void	Y	N
	Leaking		
	with coughing	Y	N
	with urgency	Y	N
	Pain with intercourse	Y	N
Male:	Testicle pain	Y	N
	Erectile dysfunction	Y	N
	Testicle mass lump	Y	N
Female:	# of pregnancies _____	deliveries	____
	# of miscarriages _____	abortions	____
	Date of last period		
	Date of last pap smear		
	MUSCULOSKELETAL		
	Arthritis	Y	N
	Back Pain	Y	N
	Joint Pain	Y	N
	ENDOCRINE		
	Diabetes	Y	N
	Pituitary disease	Y	N
	Thyroid disease	Y	N
	HEMATOLOGICAL		
	Bleeding problem	Y	N
	Swollen glands	Y	N
	Hepatitis	Y	N
	HIV (AIDS)	Y	N
	NEUROLOGICAL		
	Dizziness	Y	N
	Numbness	Y	N
	PSYCHIATRIC		
	Insomnia	Y	N
	Anxiety	Y	N
	Depression	Y	N
	Suicidal thoughts	Y	N

Physician Signature: _____ Date: _____

Name:
DOB:
Chart:
Age:
Date:

Pennsylvania Orthopedic Associates

Patient's Information

Mr/Mrs/Ms Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt/Box#: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Cell: _____ Home: _____ Work Phone: _____

Social Security #: _____

Male Female *Marital Status:* Single Married Widowed Divorced

Emergency Contact Person(s) Name: _____ Phone: _____
Relationship: _____

Primary Care Doctor: _____ City/State: _____ Phone: _____

Referring Physician: _____ City/State: _____ Phone: _____

Pharmacy: _____ City/State: _____ Phone: _____

Primary Insurance:

Company: _____
ID#: _____
Name of Policy Holder: _____
Policy Holder's Address: _____
Relationship to Patient: _____ Date of Birth: _____

Secondary Insurance:

Company: _____
ID#: _____
Name of Policy Holder: _____
Policy Holder's Address: _____
Relationship to Patient: _____ Date of Birth: _____

Name:
DOB:
Chart:
Age:
Date:

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

- **RELEASE OF INFORMATION:** I understand that Pennsylvania Orthopedic Associates may disclose the PHI (Protected Health Information) necessary for Treatment, Payment or Operations to my insurance(s), Workers' Compensation carrier or family members. PHI can also be used for communications with third party business partners of Pennsylvania Orthopedic Associates.

- **OTHER INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Pennsylvania Orthopedic Associates if I belong to a plan that is not on their list of contacts.

- **NON-COVERED SERVICES:** I understand Pennsylvania Orthopedic Associates contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services, which are "covered" by the health care service plans. **Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan.** The undersigned agrees to cooperate with Pennsylvania Orthopedic Associates to obtain necessary health care service plan authorizations.

- **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Pennsylvania Orthopedic Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Pennsylvania Orthopedic Associates for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Pennsylvania Orthopedic Associates. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Pennsylvania Orthopedic Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

- **NO-SHOW APPOINTMENT POLICY:** Our doctors want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. As of January 1st, 2016 **there <u>may be</u> a fee of $25.00 assessed if we do not receive a call to cancel an appointment within 24 hours of the scheduled time.**

SIGNATURE of patient (or responsible party): _____ **Date:** _____

Name:
DOB:
Chart:
Age:
Date:

Authorization of Use and Disclosure of Protected Health Information

I, _____ , authorize **Pennsylvania Orthopedic Associates** to disclose the information listed, to the individuals listed below.

I understand that information disclosed to this (these) individual(s) may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

ALL of my Protected Health Information may be given/released to:

- ☐ Only myself
- ☐ Spouse / significant other _____ (Name of person) _____ (Date)
- ☐ Children _____ (Name of person) _____ (Date)
  _____ (Name of person) _____ (Date)
  _____ (Name of person) _____ (Date)
- ☐ Other _____ (Relationship to patient) _____ (Name of person) _____ (Date)
  _____ (Relationship to patient) _____ (Name of person) _____ (Date)

_____ (Patient Signature) _____ (Date)

Name:
DOB:
Chart:
Age:
Date:

COMPLETE ONLY IF YOU HAVE MEDICARE

AUTHORIZATION FOR RELEASE OF INFORMATION
AND ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

PATIENT'S NAME _____ **MEDICARE #** _____

"I request that payment of authorized Medicare benefits be made to either me or on my behalf to _____ for any services furnished to me by my physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable or related services."

I understand that information will be released to the billing department of the physician and/or practice.

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster if my claim(s) is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that my physician and/or their staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and their staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____
Patient or Guardian Signature Witness

_____ _____
Date Date

A 2ND SIGNATURE IS REQUIRED FOR YOUR SUPPLEMENTAL INSURANCE

I request that payment of authorized Medigap benefits to be made either to me or on my behalf to my provider of service and/or supplier for any services furnished to me by that the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my secondary insurer, named above, any information needed to determine these benefits payable for related services.

_____ _____
Signature of Parent or Guardian Date

Name:
DOB:
Chart:
Age:
Date:

COMPLETE ONLY IF VISIT IS FOR WORKERS' COMP OR MOTOR VEHICLE ACCIDENT

WORKERS' COMP/MOTOR VEHICLE ACCIDENT

Is your injury a result of a Motor Vehicle Accident or a Workers' Comp Claim? Yes No

If so, you must provide the following information:

Name of Employer: _____

Claim #: _____ Date of Accident: _____

Name and address of insurance company: _____

Phone # of insurance company: _____

Adjuster or nurse's name & phone #: _____

Back-Up health insurance: _____

I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Pennsylvania Orthopedic Associates, Inc. release of information including protected health information to insurance companies as needed to file for payment for services incurred. Pennsylvania Orthopedics Associates, Inc. to obtain records from other sources as may be necessary in the diagnosis or treatment and understand that I am financially responsible for payment to Pennsylvania Orthopedic Associates, Inc. for charges to services provided to or incurred by me or my dependents.

Signature (Responsible Party): _____ Date: _____

For Workers' Comp Patients: All services rendered due to work-related diagnosis are billed to your employer or your employer's compensation carrier along with a narrative report of the doctor's findings. We also confirm with your employer that the history of the injury was reported to the proper individual.

Please sign below to indicate that you understood this procedure.

_____ _____
Signature Date

For Auto-Related Patients: We are required by laws to bill Insurance Carriers for all auto accidents, therefore all of the information regarding your claim must be completed including an established claim number that can be verified by this office. We do not bill attorneys - only Insurance Carriers. We require back-up health insurance for all auto accident claims.

Please sign below noting you understand this procedure and authorizing any information required by the Insurance Carrier to process your claim.

_____ _____
Signature Date