# Acknowledgement of Receipt of Privacy Notice
# Documentation of Attempt to Obtain Written Acknowledgment

As required by the Health Insurance Portability and Accountability Act of 1996, we document compliance by retaining copies of our privacy notices and any written acknowledgments of receipt of the privacy notice or documentation of good faith efforts to obtain such written acknowledgment in accordance with our obligation to provide the privacy notice at first service after compliance date, or, when an emergency occurs, as soon as possible after emergency treatment.

___I have received the Privacy Notice

Signed: ________________________________________ Date: ______________________

If not signed by patient, please indicate your relationship to the patient: ____________________

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___ We have made a good faith effort to deliver a copy of our Privacy Notice to:

Patient Name: _______________________________________________________________

Signed: ________________________________________ Date: ______________________
(Privacy contact person)

Please list person(s) authorized to discuss medical and billing information. Include any third parties such as family members, attorney offices, claim adjusters etc.

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

**I understand that I am financially responsible for all charges not paid by insurance. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of medical records. I give permission to utilize any cellular telephone numbers I provide to contact me or my responsible party. I agree to pay all costs of collection, including reasonable attorney fees for all amounts on accounts past due. After 90 days past due, accounts may be turned over to a collection agency or pursued by an attorney unless other arrangements are made with the office manager. Accounts turned over to a collection agency will accrue interest at the rate of 1.5% per month.**

**PATIENT'S SIGNATURE: _______________________________________DATE __________**

**RESPONSIBLE PARTY SIGNATURE: ________________________________ DATE __________**

REFERRING PHYSICIAN: ______________________________________________
First Name Last Name Phone Number

PRIMARY PHYSICIAN: ______________________________________________
First Name Last Name Phone Number

DATE ___/___/___

**PATIENT INFORMATION (Please Print)**

| NAME (First Name, Last Name, Middle Name) | | SOCIAL SECURITY # | DATE OF BIRTH | | MALE________<br>FEMALE________ |
|---|---|---|---|---|---|
| MAILING ADDRESS | | CITY | STATE | ZIP | HOME PHONE: |
| | | | | | WORK PHONE: |
| EMPLOYER/SCHOOL | | OCCUPATION | | | CELL PHONE: |
| EMPLOYER ADDRESS | | CITY | STATE | ZIP | PREFERRED PHONE:<br>__HOME __WORK __CELL |
| IS CONDITION AUTO RELATED?<br>YES___ NO___ | IS CONDITION WORK RELATED?<br>YES___ NO___ | OTHER ACCIDENT (please explain)<br>YES___ NO___ | | | MARITIAL STATUS<br>___SINGLE ___ MARRIED ___ OTHER |
| PARENT OR GUARDIAN'S NAME | | NEXT OF KIN | | | PHONE NO. |
| PREFERED LANGUAGE | | ETHNICITY | | | RACE |
| E MAIL ADDRESS | | | | | |

**EMERGENCY CONTACT**

| NAME | RELATIONSHIP | TELEPHONE # |
|---|---|---|
| | | |

**PRIMARY INSURANCE**

| PRIMARY INSURANCE COMPANY NAME | | MEMBER ID # | | | GROUP # |
|---|---|---|---|---|---|
| SUBSCRIBER'S NAME | SOCIAL SECURITY # | DATE OF BIRTH | | | MALE_____FEMALE______ |
| MAILING ADRESS | | CITY | STATE | ZIP | HOME PHONE |
| EMPLOYER | | OCCUPATION | | | WORK PHONE |

**SECONDARY INSURANCE**

| PRIMARY INSURANCE COMPANY NAME | | MEMBER ID# | GROUP # |
|---|---|---|---|
| SUBSCRIBER'S NAME | SOCIAL SECURITY # | DATE OF BIRTH | MALE______FEMALE______ |

**APPOINTMENT POLICY**

We respectfully ask for scheduled office appointments to be cancelled at least 24 hours in advance and scheduled surgeries to be cancelled at least 1 week in advance. We reserve the right to charge a fee of $50.00 for office visits and $500.00 for surgeries not cancelled in this time frame.

I hereby authorize ORTHOPAEDIC SPORTS SPECIALISTS to leave messages regarding my appointment.

| PATIENT SIGNATURE | DATE |
|---|---|
| | |

**MEDICARE SIGNATURE**

| NAME OF BENEFICIARY | ID # |
|---|---|
| | |

I request that payment of the authorized Medicare benefits be made either to me on my behalf or to ORTHOPAEDIC SPORTS SPECIALIST for any services furnished me by that physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, though physician of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

| SIGNATURE OF BENEFICIARY | DATE |
|---|---|
| | |

**ASSIGNMENT OF BENEFITS**

I, ______________________________________________ hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to: ORTHOPAEDIC SPORTS SPECIALISTS. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize as said assignee to release all information necessary to secure payment of said benefits.

| SIGNATURE | DATE | WITNESS |
|---|---|---|
| | | |

## Orthopaedic Sports Specialists

# *Patient History & Practice Admission Form*

Name: ____________________________ Birthdate: _____/____/___ Today's Date: ___/___/___
What Pharmacy do you use?__________ Phone_________________ Town___________________
Current problem_____________________________________________________________________
When did it begin? ____________________Who has treated you for this______________________________

**Current Medications:**

| *Drug* | *Dose* | *Rx - MD* | *Taken For* | *Date Rx* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Use back for additional Medications*

**Medication Allergies: If no known allergies please check here** ☐

| *Drug* | *Reaction* | *Date of Reaction* |
|---|---|---|
| | | |
| | | |
| | | |

**Use back for additional Medications Allergies*

**Sensitivities to Pain Medication**

| *Drug* | *YES* | *NO* | *Reaction* |
|---|---|---|---|
| Vicodin | | | |
| Anti-Inflammatory | | | |
| Other | | | |
| Sensitivity to Latex | | | |
| Radiology Contrast | | | |

**Your Other Doctors: please include your primary care physician**

| *Name* | *Specialty* | *Phone #* | *Fax #* | *Address* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Social History - *Circle all that Apply*:**

Alcohol: Denies – Heavy – Moderate – Occasionally – Never
Drug Use: Past - Present What: _________________ Caffeine
Education: High School – College – Graduate School – Physician
Employment: Full time – Part time – Retired – Disabled – Student – Unemployed Profession: __________
Marital Status: Married – Divorced – Single – Significant Other – Widowed
Tobacco: None Smoker – Cigarettes (<1 PPD, 1-3 PPD, >3 PPD) – Cigar – Chew – Quit: _____
Children: None – Number: _____ Exercise: < 3 X week, > 3 X week, None

## Family History

*Using the following key, please indicate which family member you are referring to:*

**M**= Mother **B**= Brother **MGM**= Maternal Grandmother **PGM**= Paternal Grandmother
**F**= Father **S**= Sister **MGF**= Maternal Grandfather **PGF**= Paternal Grandfather
**O**= Other (*Please specify*)

Alzheimer_____
Aneurysm_____
Arthritis_____
Bleeding Disorder_____
Blood Clots/DVT_____
Breast Cancer_____

Cancer_____
Circulatory Problems_____
Diabetes_____
Genetic Disorders_____
GI Disease or Ulcer_____
Gout_____

Heart Disease_____
High Cholesterol_____
Hypertension_____
Leukemia_____
Obesity_____
Psychiatric Disorders_____

Seizure Disorder_____
Stroke_____
Tuberculosis_____
Kidney Disease_____

## Serious Illnesses / Hospitalizations - *Circle all that Apply*:

Alcoholism
Alzheimer's Disease
Anemia
Aneurysm
Angina
Arrhythmia
Arthritis
Asthma
Bleeding Disorder
Blood Clots/DVT
Bowel Disorder
Breast Cancer
Cancer
Cerebral Palsy
Cerebrovascular Accident / Stroke
Chemotherapy
Cholelithiasis (Gallstones)
Congestive Heart Failure
COPD
Depression
Diabetes – Insulin
Diabetes – Medications
Diabetes – Diet

Diverticulitis
Eyes – Glaucoma
Eyes – Macular Degeneration
Fibromyalgia
Gastric Ulcer
GI Bleeding
Gout
Heart Disease
Heart Murmur
Heart Valve Disorder
Hepatitis Type: _____
Hiatal Hernia
Hypertension
Hyperthyroidism
Irritable Bowel Syndrome
Liver Disease
Migraine Headaches
Mitral Valve Prolapse
Myocardial Infarction (Heart attack)
Sleep Apnea
Osteoporosis
Pancreatic Disorder
Parkinson's Disease

Peripheral Vascular disease
Pneumonia
Polio
Polymyalgia Rheumatica
Prostate Cancer
Prostate Hypotrophy
Pulmonary Disease
Renal Disease
Renal Dialysis
Rheumatic Fever
Rheumatoid Arthritis
Seizure Disorder
Skin Disease
Syncope
Thromboembolism
Thrombophlebitis
Thyroid Disease
TIA's
Tuberculosis
Ulcers
Varicose Veins

## DVT Risk Factors – *please check all that apply:*

(5 points each) – check only if within the past **1 month**
___Lower extremity joint replacement
___Serious trauma (accident, broken bone, fall)
___Spinal cord injury with paralysis
___Stroke

(3 points each)
___ > 75 years
___Personal history of blood clots (DVT or PE)
___Family history of blood clots (DVT or PE)

(2 points each)
___60-74 years of age
___Current or past cancer
___Recent major surgery >45 min
___Casted limb within past month
___Central vein IV that delivers blood or medicine to your heart

(1 point each)
___41-60 years of age
___On birth control or hormone replacement
___Pregnant / gave birth within 1 month
___Current swollen legs
___Obese or overweight
___Congestive heart failure or past heart attack
___Lung disease (COPD)
___On bed rest or severely restricted mobility

Staff use only: *Total Risk Factor Score:*________________________________________(0-1 Low/ 2 Moderate/ 3-4 High / 5 or > Highest)

| Other Orthopedic Problems | R/L or Both | Date of Onset |
|---|---|---|
| | | |
| | | |
| | | |

| Past Orthopedic Operation | R/L or Both | Date of Surgery |
|---|---|---|
| | | |
| | | |
| | | |