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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ 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  | SOCIAL SECURITY# | DATE OF BIRTH | MALE\_\_\_\_\_\_\_\_FEMALE\_\_\_\_\_\_\_\_ |
| MAILING ADDRESS | CITY | STATE | ZIP | HOME PHONE: |
| WORK PHONE: |
| EMPLOYER/SCHOOL | OCCUPATION |
| CELL PHONE: |
| EMPLOYER ADDRESS | CITY | STATE | ZIP | PREFERRED PHONE:\_\_HOME \_\_WORK \_\_CELL |
| PREFERED LANGUAGE | ETHNICITY | RACE |
| E MAIL ADDRESS |
| PARENT/GUARDIAN’S NAME & PHONE NUMBER |
| **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\_\_\_\_\_\_ |

Current problem\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did it begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who has treated you for this\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Condition Auto related? Work related:

Other accident (please explain):

**Orthopaedic Sports Specialists**

***Patient History & Practice Admission Form***

What Pharmacy do you use?

Phone number: Location:

**Current Medications:**

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

*\*Use back for additional Medications*

**Allergies: If no known allergies please check here **

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

*\*Use back for additional 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: Never -- Past – Present What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caffeine?

Education: High School – College – GraduateSchool – 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 date: \_\_\_\_\_

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\_\_\_\_\_ Cancer\_\_\_\_\_ Heart Disease\_\_\_\_\_ Psychiatric Disorders\_\_\_\_\_

Aneurysm\_\_\_\_\_ Circulatory Problems\_\_\_\_\_ High Cholesterol\_\_\_\_\_ Seizure Disorder\_\_\_\_\_

Arthritis\_\_\_\_\_ Diabetes \_\_\_\_\_ Hypertension\_\_\_\_\_ Stroke\_\_\_\_\_

Bleeding Disorder\_\_\_\_\_ Genetic Disorders\_\_\_\_\_ Kidney Disease\_\_\_\_\_ Tuberculosis\_\_\_\_

Blood Clots/DVT\_\_\_\_\_ GI Disease or Ulcer\_\_\_\_\_ Leukemia\_\_\_\_\_

Breast Cancer\_\_\_\_\_ Gout\_\_\_\_\_ Obesity\_\_\_\_\_

**Serious Illnesses / Hospitalizations - *Circle all that Apply to You*:**

Alcoholism

Alzheimer’s Disease

Anemia

Aneurysm

Angina

Arrhythmia

Arthritis

Asthma

Bleeding Disorder

Blood Clots/DVT

Bowel Disorder

Breast Cancer

Cancer (Type? Date diagnosed?)

Cerebral Palsy

Cerebrovascular Accident / Stroke

Chemotherapy

Cholelithiasis (Gallstones)

Congestive Heart Failure

COPD

Depression

Diabetes

Diverticulitis

Eyes – Glaucoma

Eyes – Macular Degeneration

Fibromyalgia

Gastric Ulcer

GI Bleeding

Gout

Heart Disease

Heart Murmur

Heart Valve Disorder

Hepatitis Type: \_\_\_\_\_

Hiatal Hernia

High Cholesterol

Hypertension

Hyperthyroidism

Irritable Bowel Syndrome

Liver Disease

Migraine Headaches

Mitral Valve Prolapse

Myocardial Infarction (Heart attack)

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

Sleep Apnea

Syncope

Thromboembolism

Thrombophlebitis

Thyroid Disease

TIA’s

Tuberculosis

Ulcers

Varicose Veins

Other Orthopedic Problems R/L or Both Date of Onset

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

Past Orthopedic Operation R/L or Both Date of Surgery

|  |  |  |
| --- | --- | --- |
|  |  |  |
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**ASSIGNMENT OF BENIFITS:**

I hereby authorize ORTHOPAEDIC SPORTS SPECIALISTS, PC to release any information acquired in the course of my examination or treatment, to any person or corporation, including but not limited to, hospital service companies, insurance carriers, workmen's compensation carriers, welfare funds or employer providing such agent has a financial liability to my treatment at the medical center. I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled to: ORTHOPAEDIC SPORTS SPECIALISTS. I hereby authorize the physician and/or nurse in charge of my care at ORTHOPAEDIC SPORTS SPECIALISTS, PC to administer such treatment and hereby acknowledge that no guarantees have been made to me as to the results of treatments or examinations at ORTHOPAEDIC SPORTS SPECIALISTS, PC. 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 insurance. I hereby authorize as said assignee to release all information necessary to secure payment of said benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Signed (Patient or Parent if Minor) Date

**APPOINTMENT AND MESSAGING POLICY:**We respectfully ask for scheduled office appointments to be cancelled at least 24 hours in advance. Scheduled outpatient surgeries to be cancelled at least 1 week in advance, and total joints 3 weeks 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 and its business associates to leave voice, SMS text messages and/or email messages regarding my appointment and/or balance information. I understand I may opt-out of receiving text messages by texting a response of 'STOP' at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name Signed Cell Phone # Date

**FOR MEDICARE PATIENTS ONLY:**

I request that payment of the authorized Medicare benefits be made either to me on my behalf or to ORTHOPAEDIC SPORTS SPECIALISTS for any services furnished to 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 HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or 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.

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 Print Name Signed Date