

# Commonwealth Orthopaedics Registration Information 2010

## Patient Information

<b>Patient Name</b> <b>Account #</b> _____ _____ <b>Social Security Number</b>	<b>Home Telephone #</b> _____ <b>Work Telephone #</b> _____
<b>Address</b>	<b>Cell Telephone #</b>
<b>City, State &amp; Zip Code</b>	<b>Patient Sex</b> ___Male    ___Female
<b>FOR MEDICARE PATIENTS ONLY:</b> Do you currently reside in a Skilled Nursing Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Date of Birth</b> <b>Age</b> _____                              _____
<b>Employment/Student Status:</b> ___ Full time employed    ___ Full time student ___ Part time employed    ___ Part time student ___ Unemployed ___ Retired	<b>Employer Name &amp; Address</b> _____ _____ <b>Occupation:</b>
<b>Referring Physician:</b>	<b>Email Address (please print)</b> _____
<b>Family Physician:</b>	<b>Married</b> ____ <b>Single</b> ____ <b>Other</b> ____

## Financially Responsible Person (if different from above)

<b>Full Name</b> _____ <b>Address</b> _____ <b>City, State &amp; Zip Code</b> _____ <b>Date of Birth</b> _____	<b>Social Security Number</b> _____ <b>Home Telephone #</b> _____ <b>Work Telephone #</b> _____ <b>Cell Telephone #</b> _____
<b>Employer Name</b> _____	<b>Relationship to the Patient (circle one)</b> Self   Spouse   Child   Parent   Other

## Insurance Company Information

<b>Primary Insurance Company Name</b>	<b>Secondary Insurance Company Name</b>
<b>Address, City, State &amp; Zip</b>	<b>Address, City, State &amp; Zip</b>
<b>Policy Holder</b> <b>Date of Birth</b>	<b>Policy Holder</b> <b>Date of Birth</b>
<b>Policy Holder Employer</b> <b>Policy Holder SSN</b>	<b>Policy Holder Employer</b> <b>Policy Holder SSN</b>
<b>Policy Number</b> <b>Group Number</b>	<b>Policy Number</b> <b>Group Number</b>
<b>Relationship to the Patient (circle one)</b> Self   Spouse   Child   Parent   Other	<b>Relationship to the Patient (circle one)</b> Self   Spouse   Child   Parent   Other

Date Reviewed \_\_\_\_\_ Initials \_\_\_\_\_

**Appointment Information:**

**Patient Name:** \_\_\_\_\_ **Account#:** \_\_\_\_\_

**Name of Physician to see today:** \_\_\_\_\_

**Name of Physician who referred you here today:** \_\_\_\_\_

**Body Area being seen for today:** \_\_\_\_\_

<b>Problem?</b>	<b>Y N</b>	<b>Date problem began</b>	_____
<b>Injury?</b>	<b>Y N</b>	<b>Date of Injury</b>	_____
<b>Work Injury</b>	<b>Y N</b>	<b>Date of Injury</b>	_____
<b>Auto Accident</b>	<b>Y N</b>	<b>Date of Accident</b>	_____ <b>State of Accident</b> _____

**Emergency Contact Information:**

**Name** \_\_\_\_\_ **Telephone Number** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_

**Insurance Authorization and Assignment of Benefits**

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Commonwealth Orthopaedics and Rehabilitation, PC, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Patients**

If you are covered by Medicare, please read and sign the following:

In Medicare cases, Commonwealth Orthopaedics and Rehabilitation, PC, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Medical History

Patient Name: _____ Date _____ Age: _____ Height _____ Weight _____	<b>Office Use Only</b> BP _____ P _____ R _____ T _____
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**Chief Complaint:**  Pain  Numbness  Weakness  Stiffness  Swelling  Popping/Grinding  Unstable  
 Other \_\_\_\_\_

**Body Part Affected:**  Right  Left \_\_\_\_\_

**Date of injury or onset of symptoms** \_\_\_\_\_

**Where did the injury/symptoms occur?**  at home  at work  during sports/recreational  car accident  at school  
 Other \_\_\_\_\_

**How did the injury/symptoms occur?**  sudden/traumatic  lifting/bending  gradual onset  injury relating to a fall  
 recurrence of previous injury  Other \_\_\_\_\_

**Allergies:**  No known allergies  Latex  Soy  Eggs  Penicillin  Sulfa  Iodine  Shellfish  Radiological dyes  
 Other \_\_\_\_\_

**Current Medications:**  None

List prescription and non-prescription medications, including vitamins, herbal and nutritional supplements.

Medication	Dose	How Often	Medication	Dose	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Review of Systems: (Check all that apply)**

**General:**  NONE  Excessive fatigue  Weakness  Fever  Exercise intolerance  Other \_\_\_\_\_

**Eye Problems:**  NONE  Blurred vision  Double vision  Cataracts  Glaucoma  Light sensitivity  
 Glasses/Contacts  Other \_\_\_\_\_

**Ears, Nose, Throat, Mouth:**  NONE  Difficulty swallowing  Nose bleeds  Sore throat  Ear pain  Seasonal allergies  
 Hard of hearing  Other \_\_\_\_\_

**Cardiovascular:**  NONE  High blood pressure  Heart attack  Chest pain  Palpitations  Blood clots  
 Murmur  Other \_\_\_\_\_

**Respiratory:**  NONE  Shortness of breath  Asthma  Sleep apnea  chronic cough  wheezing  
 Other \_\_\_\_\_

**Stomach/Intestinal:**  NONE  Heartburn  Nausea  Vomiting  Abdominal pain  Gallbladder problems  
 Other \_\_\_\_\_

**Kidney/Bladder:**  NONE  Painful urination  Frequent urination  Incontinence  Frequent bladder infection  
 Enlarged prostate  Other \_\_\_\_\_

**Musculoskeletal:**  NONE  Muscle cramps  Joint stiffness  Joint pain  Joint swelling  Other \_\_\_\_\_

**Skin Problems:**  NONE  Itching  Excessive dryness  Hives  Dermatitis  Other \_\_\_\_\_

**Neuro/Psychological:**  NONE  Anxiety  Depression  Headaches  Memory loss  Seizures  ADD/ADHD  
 Other \_\_\_\_\_

**Endocrine Problems:**  NONE  Weight gain  Weight loss  Diabetes  Thyroid problems  Gout  Liver problems  
 Other \_\_\_\_\_

**Hematologic:**  NONE  Bruise easily  Prolonged bleeding  Anemia  Other \_\_\_\_\_

**Reproductive:**  NONE  Pelvic pain  Heavy Bleeding  Cysts  Other \_\_\_\_\_

If female, are you pregnant?  Yes  No      Date of last menstrual period: \_\_\_\_\_



## Financial Policy

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable copay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. Furthermore, if you do not pay your copay at the time of your appointment, we retain the right to levy an administrative charge of \$20. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance requires prior to your visit.

If you do have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. In addition to the principal balance due, you will also be responsible for any legal or collection agency fees incurred. Any payment made to us in the form of a check that is returned for insufficient funds will incur a \$25 fee per incidence.

## Cancellation Policies

**Physician Offices:** If you fail to provide us with a 24 hour notice of cancellation or fail to keep your scheduled appointment, we reserve the right to charge you a \$30 no show fee.

**Physical Therapy:** If you fail to provide us with a 24 hour notice of cancellation, you will be charged a \$30 cancellation fee. If you are unable to keep your scheduled appointment and do not notify us, you will be charged a \$50 no show fee. If you schedule an initial evaluation appointment and fail to keep the appointment, you will be charged a \$130 fee.

**Surgery:** If you fail to provide us with at least 7 (seven) days notice of cancellation or fail to keep your scheduled surgery, we reserve the right to charge you a \$250 fee.

## Surgery Policies

If you have surgery performed in one of Commonwealth's outpatient surgery centers, you will receive three separate charges for the services provided: one for the surgeon's fee, one for the facility, and one for the anesthesiologist. If you have surgery in an outside facility (a hospital or non-Commonwealth surgery center), you will receive a bill from us representing the surgeon's fee. In addition, you likely will receive separate bills for services rendered by the hospital, anesthesiology, and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

## Durable Medical Equipment

There may be occasions when your course of treatment requires the use of an orthopaedic appliance or soft goods to facilitate your rehabilitation. In these instances, we will verify your benefits and file a claim to your insurance company when applicable. In cases where insurance does not cover the required equipment we do require payment in full for the equipment at the time of service.

## Consent

My signature below indicates my full understanding and consent to the above described policies. Additionally, I provide authorization to my insurance company to pay any applicable benefits directly to Commonwealth Orthopaedics & Rehabilitation, P.C.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor signature (if guarantor is not patient)

\_\_\_\_\_  
Date

## Acknowledgment of Notice of Privacy Practices and Permission of Disclosure

I acknowledge that I was made aware of Commonwealth Orthopaedic's Privacy Policy and a copy was available for my review.

I authorize the following person(s) access to my protected health information (PHI).

Name	Date of Birth
_____	_____
_____	_____
_____	_____

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Patient Printed Name

Date

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Patient Signature

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Printed Name of Personal Representative

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Signature of Personal Representative

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Relationship of Personal Representative to Patient

## Notice of Disclosure of Ownership Interest

Commonwealth Orthopaedics & Rehabilitation, P.C. (Commonwealth Orthopaedics) is wholly owned by a subset of the physicians who provide care in the offices of Commonwealth Orthopaedics. The same group of physician owners also owns the outpatient surgery centers and physical therapy clinics associated with Commonwealth Orthopaedics. Because the physicians own the surgery centers and physical therapy operations, they are best able to ensure the highest level of care is provided to you. A schedule of fees related to the services you might receive can be provided at your request. You have the right to request that services be provided at locations other than those described above.

*By my signature below, I am acknowledging this Notice of Disclosure of Ownership Interest on the date set forth below.*

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Patient Signature

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Date

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Patient's Agent/Representative

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Relationship to Patient