Commonwealth Orthopaedics Registration Information 2012

Patient Information

Patient Name **Account #** ___________ _____________________________________ **Social Security Number**	**Home Telephone #**__________________ **Work Telephone #** __________________ **Cell Telephone #** ___________________
Address	**Patient Sex** ___**Male** ___**Female**
City, State & Zip Code	**Date of Birth** **Age** _______________ ___________
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? [ ] YES [ ] NO	**Emergency Contact Name & Phone** ______________________________________ **Relationship to Patient** ______________________________________
Employment/Student Status ___Full time employed ___Full time student ___Part time employed ___Part time student ___Unemployed ___Retired	**Employer Name & Address** _____________________________________ _____________________________________ **Occupation**
Referring Physician **Family Physician**	**Email Address** **(please print)** _____________________________________ **Married** _____ **Single** _____ **Other** _____ **Spouse's Name**
Patient Smoking Status [ ] Current Everyday Smoker [ ] Current Someday Smoker [ ] Smoker, current status Unknown [ ] Never Smoker [ ] Former Smoker [ ] Unknown if ever Smoker **Ethnicity of Patient** [ ] Hispanic Origin [ ] Non Hispanic Origin [ ] Unknown [ ] Declined to answer	**Race of Patient** [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian/Other Pacific Islander [ ] White [ ] Unknown [ ] Declined to answer **Preferred Language of Patient** [ ] English [ ] Spanish [ ] Other ______________________

In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.

Financially Responsible Person (if different from above)

Full Name ____________________________________ **Address** ____________________________________ **City, State & Zip Code** ____________________________________ **Date of Birth** ______________________	**Social Security Number** _______________ **Home Telephone** # ______________________ **Work Telephone** # ______________________ **Cell Telephone** # ______________________
Employer Name _______________________________________	**Relationship to the Patient (circle one)** Self Spouse Child Parent Other

Date Reviewed ______ **Initials** ______

Insurance Company Information

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

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: ____

Problem? Y N **Date problem began** ________________
Injury? Y N **Date of Injury** ______________________
Work Injury Y N **Date of Injury** ______________________
Auto Accident Y N **Date of Accident** _____________**State of Accident** _______

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_________

Commonwealth
Orthopaedics
Getting back to *your* life.

Patient Medical History

Name:______________________________ Date:______________

Age:__________ Date of Birth:______________ Height:__________ Weight:__________

CHIEF COMPLAINT

Why are you seeing the doctor today?______________________________

Have you been treated for this problem before? ❑ Yes ❑ No

Date of Injury/Onset of problem______________________________

Current problem is a result of: *Check all that apply:*

❑ Car Accident ❑ Work Accident ❑ Other *(specify)*______________________________

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No	Condition
❑	❑	Anemia
❑	❑	Arthritis
❑	❑	Asthma
❑	❑	Birth Defects
❑	❑	Bladder Problems
❑	❑	Bleeding or Bruising
❑	❑	Cancer Type_______
❑	❑	Diabetes
❑	❑	DVT/Blood Clots
❑	❑	Epilepsy
❑	❑	Gallbladder Problems
❑	❑	Gout
❑	❑	Heart Disease
❑	❑	Hepatitis
❑	❑	HIV/AIDS
❑	❑	High Blood Pressure
❑	❑	High Cholesterol
❑	❑	Intestinal/Bowel Problems
❑	❑	Kidney Problems
❑	❑	Liver Disease
❑	❑	Lung Problems
❑	❑	Phlebitis
❑	❑	MRSA/Staph Infection
❑	❑	Osteoporosis
❑	❑	Peripheral Vascular Disease
❑	❑	Polio
❑	❑	Psychological problems
❑	❑	Pulmonary Embolism
❑	❑	Rheumatic Fever
❑	❑	Sexually Transmitted Disease
❑	❑	Stroke/TIA
❑	❑	Tuberculosis
❑	❑	Thyroid Problems
❑	❑	Ulcer Type________

Are there any other medical problems we should know about?______________________________

____

Are you right or left-hand dominant? ❑ Right ❑ Left

Do you exercise or participate in sports regularly? ❑ Yes ❑ No

Are you or could you be pregnant? ❑ Yes ❑ No

Type and Frequency:______________________________

MEDICATIONS *Please list all medications you take with or without a prescription (use extra paper if needed)*

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES *Please describe any current or past allergic reactions*

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was/is the reaction treated?

❑ I DO NOT have any drug allergies

SURGERIES AND HOSPITALIZATIONS

❑ Arthroscopy ______________ Year ______ Physician__________ Complication?__________

❑ Joint replacement ______________ Year ______ Physician__________ Complication?__________

❑ Bone or joint reconstruction ______________ Year ______ Physician__________ Complication?__________

❑ Spine surgery ______________ Year ______ Physician__________ Complication?__________

❑ Other general surgery______________ Year ______ Physician__________ Complication?__________

______________ Year ______ Physician__________ Complication?__________

❑ Other hospitalizations ______________ Year ______ Physician__________ Complication?__________

❑ I HAVE NOT HAD any surgeries or hospitalizations

Over →

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
❏	❏	Alzheimers	❏	❏	Diabetes	❏	❏	Osteoporosis	Other ________________
❏	❏	Arthritis	❏	❏	Gout	❏	❏	Stroke	________________
❏	❏	Cancer	❏	❏	Heart Disease	❏	❏	Sudden Death	________________

SOCIAL HISTORY

Do you smoke or chew tobacco? ❏ Yes ❏ No Number: _____ packs per day for _____ years

Do you drink alcoholic beverages? ❏ Yes ❏ No Amount and frequency: __________________________

Do you use recreational drugs? ❏ Yes ❏ No Type and frequency:_____________________________

REVIEW OF SYSTEMS *Please check the following symptoms you have experienced on a regular basis:*

GENERAL
- ❏ Fever
- ❏ Weight Change
- ❏ Hormonal problems
- ❏ Other___________
- ❏ NONE

CARDIOVASCULAR
- ❏ Chest Pain
- ❏ Palpitations
- ❏ Fluid/swelling in extremities
- ❏ Other___________
- ❏ NONE

KIDNEY/BLADDER
- ❏ Painful urination
- ❏ Frequent urination
- ❏ Incontinence
- ❏ Other___________
- ❏ NONE

EYES
- ❏ Glasses/contacts
- ❏ Cataracts
- ❏ Glaucoma
- ❏ Other___________
- ❏ NONE

RESPIRATORY
- ❏ Shortness of breath
- ❏ Sleep apnea
- ❏ Wheezing
- ❏ Other___________
- ❏ NONE

EARS, NOSE, THROAT
- ❏ Difficulty swallowing
- ❏ Ear pain
- ❏ Seasonal allergies
- ❏ Hard of hearing
- ❏ Other___________
- ❏ NONE

GASTROINTESTINAL
- ❏ Heartburn
- ❏ Diarrhea/Constipation
- ❏ Abdominal pain
- ❏ Nausea/vomiting
- ❏ Other___________
- ❏ NONE

SKIN
- ❏ Rashes
- ❏ Lumps
- ❏ Other___________
- ❏ NONE

HEMATOLOGIC/LYMPHATIC
- ❏ Anemia
- ❏ Blood problems
- ❏ Clotting disorder
- ❏ Lymph problems
- ❏ Other___________
- ❏ NONE

NEUROLOGICAL
- ❏ Headaches
- ❏ Numbness
- ❏ Tingling
- ❏ Seizures
- ❏ Weakness
- ❏ Other___________
- ❏ NONE

PSYCHOLOGICAL
- ❏ Anxiety
- ❏ Depression
- ❏ Mood swings
- ❏ Other___________
- ❏ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1-10.

No Pain 0	1	2	3	4	5	6	7	8	9	Extreme Pain 10

Patient Name:____ **Date:**________________

Patient Signature:____ **Date:**________________

Reviewed by:____ **Date:**________________

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 or cancel within 24 hours, you will be charged a $75.00 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
____________________	____________
____________________	____________
____________________	____________
____________________	____________

Patient Printed Name Date

Patient Signature

Printed Name of Personal Representative

Signature of Personal Representative

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.

Patient Signature

Date

Patient's Agent/Representative

Relationship to Patient