REGISTRATION SHEET

Dr.________________________________ Date_______________

PATIENT INFORMATION

Name_________________________________
Address ______________________________
City/State _____________________Zip________
Sex: ☐ Male ☐ Female
Are you a Student? ☐ Full-time ☐ Part-Time
Are you employed? ☐ Yes ☐ No
Employer_______________________________
Address ________________________________

Date of Birth (mo) ______ (day) ______ (yr) ______
Home Phone # ______________________________
Cell Phone # _______________________________
Work Phone # _______________________________
Email Address:______________________________
Marital Status ☐Married ☐ Single ☐ Divorced ☐ Widowed
Emergency Contact ___________________________
Emergency Daytime Phone # ____________________
Pharmacy Name # ____________________________
Pharmacy Phone # ____________________________

BILLING INFORMATION (IF DIFFERENT THAN PATIENT)

Bill to Name__________________________________
Address______________________________________
City, State, Zip________________________________

Relationship to Patient__________________________
Home Phone# ______________Work#_____________
Date of Birth (mo)_______(day)_______(yr)________

HEALTH INSURANCE INFORMATION

PRIMARY (If you are not the policyholder, please complete the section below.)

Insurance Company Name____________________
Name of Policyholder_______________________
Date of Birth (mo)_______(day)_______(yr)______
Sex: ☐ Male ☐ Female

Relationship to Patient__________________________
Employer______________________________________
Employment Status: ☐ Active ☐ Retired

SECONDARY (If you are not the policyholder, please complete the section below.)

Insurance Company Name ____________________
Name of Policyholder_______________________
Date of Birth (mo)______(day)_______(yr)_______
Sex: ☐ Male ☐ Female

Relationship to Patient__________________________
Employer______________________________________
Employment Status: ☐ Active ☐ Retired

In compliance with Orthopedic Associates' participation in a government program on patient quality of care we ask that you provide the following information (please note that you have the option to decline to answer these questions)

Race: ☐African-American ☐ Asian ☐ American Indian ☐ Caucasian ☐ Hispanic ☐Native Hawaiian ☐ Other Race

Preferred Language: ______________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

FINANCE AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Orthopedic Associates, S.C. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

CO-PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signature_______________________________________ **Date**____________________

(If Minor – Parent or Guardian Signature)

Orthopaedic History

Name: ______________________ **Today's Date:** ______________________

SS#: ______________________ **Date of Birth:** ______________________

Medications you take: (*please list all*) ☐ None

Medication	Dosage and Frequency	Reason For Taking

Herbal Supplements you take: ______________________

ALLERGIES to Medications: (*please list all*) ☐ No Known Allergies

____

____

Allergic to metal? ☐ Yes ☐ No
If yes, which type? ______________________

Are all immunizations up to date? ☐ Yes ☐ No
If no, Which immunizations are due? ______________________

Medical History: (*please check all that apply*) ☐ None apply

☐ Heart attack	☐ Osteoporosis	☐ Stomach ulcers	☐ Phlebitis
☐ Heart failure	☐ Asthma	☐ Kidney stones	☐ Blood clots in legs
☐ Heart murmur	☐ Tuberculosis	☐ Kidney failure	☐ Blood clots in lungs
☐ High blood pressure	☐ Emphysema	☐ Transplants	☐ Bleeding disorders
☐ Stroke	☐ Lung disease	☐ Chemical abuse	☐ Scarring tendency
☐ Diabetes	☐ Blood vessel disease	☐ Alcohol dependence	☐ Sickle cell disease
☐ High cholesterol	☐ Osteoarthritis	☐ HIV positive / AIDS	☐ Peripheral neuropathy
☐ Rheumatoid arthritis	☐ Mental illness	☐ Hepatitis	☐ Peripheral arterial disease
☐ Liver trouble	☐ Sleep apnea	☐ Hyperthyroidism	☐ Peripheral vascular disease
☐ Lupus	☐ ADHD / ADD	☐ Hypothyroidism	☐ Coronary artery disease
☐ GERD	☐ Gout	☐ Hyperlipidemia	☐ Herniated disc
☐ Cancer: __________	☐ Other: ______________________		☐ Spinal stenosis

Surgical History: ☐ None

Operation (*exclude child birth*)	Date or Approx. Age	Surgeon	Hospital

History of anesthesia problems: ______________________ ☐ None

Surgical Complications: (*ie: Infection*) ______________________ ☐ None

Other Hospitalizations: (*not for surgery*) ☐ None

Reason	Date or Approx. Age

Other Major Illness or Injury: ☐ None

Description	Date or Approx. Age

Family History: (*please check all that apply*) ☐ None apply

Condition	Which Family Member	Condition	Which Family Member
☐ Heart disease		☐ Scoliosis	
☐ Stroke		☐ Spinal problems	
☐ High blood pressure		☐ Kidney failure	
☐ Diabetes		☐ Mental illness	
☐ Osteoporosis		☐ Bleeding/Blood clots	
☐ Rheumatoid arthritis		☐ Anemia	
☐ Osteoarthritis		☐ Alcohol dependence	
☐ Lupus		☐ Cancer of:	
☐ Sickle cell disease		☐ Other: (*list*)	

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Describe the type of work you do: ____________________

Are you or could you possibly be pregnant? (*women only*) ☐ Yes ☐ No

Risk Factors *Patients 13 years old and over*

Do you smoke or use tobacco? ☐ Everyday ☐ Occasionally ☐ Former ☐ Never

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? ____________________

Do you exercise regularly? ☐ Yes ☐ No How often? ____________________

What is your primary exercise activity? ____________________

____________________ Date: ____________________

Signature of Patient (or Guardian if minor)

Reviewed by: ____________________ M.D./D.O. Date: ____________________

PATIENT QUESTIONNAIRE

☐ Initial Visit ☐ New Problem ☐ Recurrent Problem

PATIENT NAME:____ **AGE**:__________

PHYSICIAN: ☐ Dr. Kim ☐ Dr. Sladek ☐ Dr. Moss

Who is your primary care physician? Name:____________________**City:**__________

Whom may we thank for referring you to our practice?_____________________________

1. Date of ☐ illness ☐ accident or ☐ injury: Mo_______Day______Year________

2. What part of your body are you being seen for ?________________ ☐ Left ☐ Right

3. Where did the accident or injury happen? ☐ work ☐ auto accident ☐ home

   ☐ other please specify: ____

4. How did the accident or injury happen? _____________________________________

   ____

5. Have you been treated for this problem somewhere else? ☐ Yes ☐ No

   If yes, where?___________________________When?________________________

6. Did you bring x-rays with you today? ☐ Yes ☐ No

   Where were the x-rays taken? ☐ NWCH ☐ Treatment Center (which one) ___________

   ☐ Other, please specify ____

Signature____**Date**______________

Request for Confidential Communication

I, _________________________, hereby request Orthopedic Associates, SC
(Name of Patient or Authorized Agent)

to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at ___________________________

Leave messages on answering machine: ____ Yes ____ No

Leave message with any other person: ____ Yes ____ No

FAX: ____ Please do not contact me by FAX

____ Please contact me by FAX at _______________________

May we discuss your protected health information with any family members?

____ Yes Name and relationship___________________________________

____ No

Other Requests for Confidential Communications: __________________________________

____

____

This request may be changed or revoked by filing a new request or revoking this one in writing.

Signed: ____ Date: ___________________

If you are not the patient, please specify your relationship to the patient: ___________________

– Patient's file

ORTHOPEDIC ASSOCIATES, SC
415 W GOLF RD, SUITE 68
ARLINGTON HTS, IL 60005

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, ______________________, hereby give my consent to Orthopedic Associates, SC
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________________.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me at the office or by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ____Date: _________________

If you are not the patient, please specify your relationship to the patient __________________.

– Patient's file

CONSENT FORM DEFINITIONS

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

ORTHOPEDIC
ASSOCIATES, S.C.
415 W. GOLF RD., SUITE 68 ARLINGTON HEIGHTS, IL 60005 (PHONE) 847-593-5511 (FAX) 847-593-0872

CANCELLATION AND NO-SHOW POLICY

The staff at Orthopedic Associates would like to thank you for choosing us as your provider. We understand that sometimes events beyond your control will force you to miss your appointment.

In order that we can provide you and all of our patient's with the best service possible, we ask that you adhere to the following:

- If you arrive more than **15 minutes** late we may need to reschedule your appointment.
- If you need to cancel an appointment, please give us 24 hours notice by calling 847-593-5511, if no-one answers, please leave a message on our voice mail.
- You may be charged a fee of **$25.00-$50.00** (depending on the appointment type) for no-shows or cancellations without 24 hours' notice. This amount will be charged directly to you, not your insurance company.

Your understanding and cooperation is appreciated.

I have read and understand this policy.

____
Patient's Name (Please Print)

_______________________________ ______/______/______
Signature of patient/policyholder Date Signed

____
Relationship, if not patient