Orthopedics Associates of Riverside

Nicholas Anderson D.P.M Michael J. Hejna MD, PhD Erling Ho MD Scott A. Seymour MD

Past Medical History

Patient Name: (Last)_____ (First) _____ **DOB:**_____

Occupation: _____ **Height:** _____ **Weight:** _____

Reason for today's visit: (circle) Left / Right _____

Duration of Symptoms: _____ Allergies: _____

Alcohol Use: (circle) Yes/Occasional/No Tobacco Use: (circle) Yes/No

Current Medications: _____

_____

Preferred Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address/Intersection: _____ Pharmacy Zip code: _____

Primary Care Doctor

Primary Care Doctor Name: _____ Phone Number: _____

Past Orthopedic Problems: _____

_____

Previous Surgeries: _____

_____

Family Medical History: _____

_____

Have you ever had any of the following conditions? (**Please check or circle all that apply**)

History of Cancer: (circle) Yes/No If Yes Type of cancer: _____Treatment: Chemo/Radiation/Beads

___Heart Disease	___Sleep Apnea	___Asthma
___Pacemaker	___Neuropathy	___HIV/AIDS
___High Blood Pressure	___COPD	___Gout
___Ulcer/GI bleeding	___Recent Weight Loss	___Rheumatoid Arthritis
___Circulatory Problems/Blood Clots	___Back Problems	___Osteoporosis
___Diabetes	___Liver Disease/Hepatitis	___Osteoarthritis
___DVT	___Hypothyroidism	___Fibromyalgia
___High Cholesterol	___Kidney Disease	___Psychiatric Care
___Afib	___Recurrent UTI's	___Epilepsy
___Joint Replacement	___Stroke	___Depression/Anxiety
___ Artificial Heart Valves	___ Acid Reflux	Addictions: (circle)Drug/Alcohol/Other

___Other medical conditions not listed: _____

Patient/Guardian Signature: _____ **Today's Date:** _____

If under age Print Guardian Name: _____ Relationship to Patient: _____

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Patient Profile Information

Patient Name: (Last)_____ (First) _____ DOB:_____ Sex:(circle)F/M

Address: _____ City: _____ State: _____ Zip code: _____

Marital Status: (circle) Single/Married/Divorced/Widowed/Other Preferred Language: _____

Preferred Phone Number: _____ (circle) Cell / Work Email: _____

May we leave a voicemail message at your preferred number? (circle) Y/N

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Employer Information

Is the injury work related/Workers' compensation? (circle) Y/N (If yes, please fill out Workers' Comp Form)

Employer Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip code: _____

Guarantor/Insurance Information

Insurance Holder Name: _____ DOB: _____ Relationship: _____

Insurance Name: _____ ID# _____ Group#: _____

Authorization to Acquire Medication History/E-Scribe: I hereby authorize OAR, its physicians' and medical personnel (under physician direction) to send/acquire my medication history via electronic health records.

Patient/Guardian Signature: _____ If under age, specify relationship: _____

Consent to Treatment and Financial Responsibility

Consent: I hereby authorize OAR, its physicians' and medical personnel (under physician direction) to conduct such examination; administer treatment and medications, as they deem necessary and advisable.

Financial Responsibility: OAR will, as a convenience to its patients, bill insurance companies for services rendered. However, payment for services rendered is the sole responsibility of the patient and/or legal guardian. Failure of an insurance company to remit payment DOES NOT relinquish the patient and/or guardian from financial responsibility.

Patient/Guardian Signature: _____**Today's Date:** _____

If under age Print Guardian Name: _____ Relationship to Patient: _____

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HIPAA-Receipt of Notice of Privacy Practices

Patient Name: (Last)_____ (First) _____ **DOB:**_____

I, *(Patient Name/Authorized Agent)* _____, hereby give my consent to OAR to use or disclose, for the purpose of caring out treatment, payment, or healthcare operations, all information contained in the patient record of the above mentioned. 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 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 at the main office located 353 E Burlington St, Suite 100, Riverside, IL 60546.

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.

Authorization to Release Information

The HIPAA Privacy Act of April 2003 prohibits us from speaking to anyone other than yourself, your legal guardian or your power of attorney (POA) in regards to not only your medical condition but your medical bills as well. We have found that this causes frustration for family members when trying to assist their loved ones with medical decisions and financial situations. To that end we would like to minimize these frustrations by asking that you give prior approval for anyone you may want to grant us authorization to speak with. ***Please understand that it is your right to refuse to authorize us to speak with anyone, however if not expressly granted permission to do so, our staff will not be able to speak to anyone other than yourself, your legal guardian or your power of attorney. Please note that workers compensation claims are not subjected to the HIPAA Privacy Act and that medical records and financial information will be released to your employer, worker's compensation carrier and/or their employees for purposes of obtaining payment.***

I hereby I've received HIPAA Notice of Privacy Practices and I authorize representatives of OAR to speak with:

Name of Individual (**PRINT ONLY**)	***Relationship*** (**PRINT ONLY**)
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Today's Date:** _____

If under age Print Guardian Name: _____ Relationship to Patient: _____

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Designation of Authorized Representative Form

Patient Name: (Last)_____ (First) _____ **DOB:**_____

I, *(Patient Name/Guardian)* _____, do hereby designate all employees of ***Orthopedic Associates of Riverside & Orthopedic Associates of Riverside Physical &Occupational Therapy***, to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29 CFR 2560-503-1(b)4, to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee healthcare benefit plan, with respect to any medical or other healthcare expenses incurred as a result of the services I receive(d) from the above named.

These rights include:

1. The right to act on my behalf with respect to initial determinations of claims
2. The right to pursue appeals of benefit determinations under my plan
3. The right to obtain any records related to my Protected Health Information, including health plan
4. The right to claim on my behalf such medical or other healthcare service benefits, insurance or Healthcare benefits plan reimbursement and to pursue any other applicable remedies.

I understand that as a result of this authorization, (insurance name) _____ may disclose and release any information concerning benefit eligibility, claim status/claim approval/denial reasons in connection with the above referenced healthcare claim to the above named.

Expiration: This authorization will expire **1 year from date of signature.**

Right to Revoke: I understand I may revoke this authorization at any time by giving written notice to my insurance company and the above named. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

Signature: I understand this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment, or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Patient/Guardian's Signature:_____ **Today's Date:** _____

Completion of Disability/FMLA or other forms & Appointment Cancelation Policy

Do to the overwhelming request for our medical providers to complete paperwork and in effort to be fair to all our patients, we have the following policy in place:

1. All forms (no exception) require a $20 pre-payment and all forms must be presented at time of service to front desk prior to see your medical provider.
2. Please allow 7-10 business days for completion of forms.
3. For surgery/workers' compensation patients a Work Status Form (WST) will be provided at no charge
4. ALL appointments REQUIRE a 24-48hr notice otherwise a fee of $30 will be collected before scheduling next appointment.

Patient/Guardian Signature: _____**Today's Date:** _____

If under age Print Guardian Name: _____ Relationship to Patient: _____