TRI-COUNTY ORTHOPEDICS

World-Class Team. Hometown Choice.

______________________________ Patient Name	____ Age	____/____/____ Date of Birth	____/____/____ Today's Date
____ Phone Number			New Patient to the Practice Established Patient to the Practice

Primary Physician: ________________________ Phone #: _________________________

Cardiologist: _____________________________ Phone #: _________________________

Pharmacy Name: __________________________ Street: ___________________________ Town: ______________

What is the reason for today's visit? ____ Left ( ) Right ( )

How did this problem occur? ____

When/where did this happen? ____

Have you had X-rays taken for this problem? Yes No If yes, indicate date/place:________________________

Have you had physical therapy for this problem? Yes No If yes, for how long: ____________________________

Have you tried any medications for this problem? Yes No If yes, list names:________________________________

____

Past Medical History:

Do you have (or have you had) any of the following medical problems? **OR CHECK ❑ NONE**

- ❑ High Blood Pressure
- ❑ Heart Disease (Heart Attack /Stent Placement)
- ❑ Stroke/TIA
- ❑ Arrhythmias/CHF
- ❑ High Cholesterol
- ❑ Migraine Headaches
- ❑ Diabetes
- ❑ Underactive Thyroid
- ❑ Overactive Thyroid
- ❑ Osteoporosis
- ❑ Asthma
- ❑ Seizures
- ❑ Alcoholism/Substance Abuse
- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Breast Cancer
- ❑ Prostate Cancer
- ❑ Ulcers/Stomach Bleeding
- ❑ Kidney Failure/One Kidney
- ❑ Prior History of Sleep Apnea

OTHER Medical History____

Height: ____ft. ____in. Weight: ______lbs.

Have you ever had **a blood clot** or **deep venous thrombosis**? Yes No If yes, please explain:_________

____

Past Surgical History:

Have you had any type of surgery? Yes No If yes, please list: ____

____

____

Medication Allergies:

Please **list any medication** to which you have an allergy and **explain your reaction**: ________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Are You Allergic To: ❑ LATEX ❑ NICKEL ❑ NONE

Medications:

Do you regularly take any medications? Yes No If yes, please list: _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Social History:

Occupation: ________________________________ or Current School Name: ____________________________

Do you smoke? No Yes, _____cig/day for _____years

Do you drink alcohol? No Yes, _____drinks/day OR _____drinks/wk OR _____occasional use

Family History:

List any medical problems that run in your family: ____

____

Review: Please check if you currently have any of the following: **OR CHECK ❑ NONE**

• Unexpected weight loss?	Yes	No	• Diarrhea?	Yes	No
• Unexpected weight gain?	Yes	No	• Nausea/Vomiting?	Yes	No
• Visual changes?	Yes	No	• Constipation?	Yes	No
• Fevers?	Yes	No	• Pain with urination?	Yes	No
• Headaches?	Yes	No	• Frequent urination?	Yes	No
• Cold sores?	Yes	No	• Incontinence?	Yes	No
• Coughing?	Yes	No	• Rashes?	Yes	No
• Wheezing?	Yes	No	• Breast pain?	Yes	No
• Shortness of breath?	Yes	No	• Nipple discharge?	Yes	No
• Phlebitis?	Yes	No	• Lumps in breast?	Yes	No
• Chest pains?	Yes	No	• Blood sugar problems?	Yes	No
• Palpitations?	Yes	No	• Thyroid problems?	Yes	No
• Leg Swelling?	Yes	No	• Severe night sweats?	Yes	No
• Mood Changes?	Yes	No	• Snoring/Irregular Breathing?	Yes	No
• Depression?	Yes	No	• Non-Restorative Sleep/Daytime Sleepiness?	Yes	No
• Anxiety?	Yes	No			

*X*____ ____________________________

Patient Signature **Date**

*X*____ ____________________________

MD Signature **Date**

To be completed by the physician

Date reviewed: ____________ Any Changes? _ Yes _ No ________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No ________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No ________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No ________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No ________________________________
MD Signature

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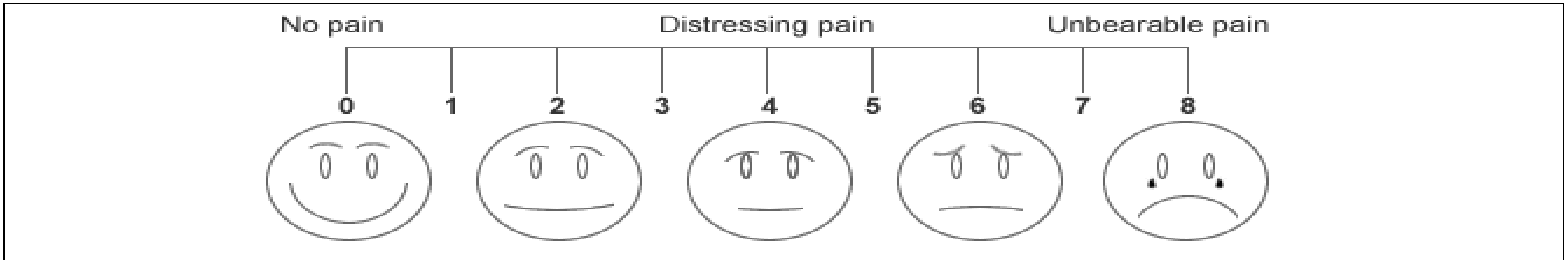
Have there been **ANY CHANGES** in your **MEDICATIONS** since your last visit? ◇ Yes ◇ No **If yes**, please list below:		
MEDICATION NAME	**DOSAGE**	**DIRECTIONS**

Have there been **ANY NEW ALLERGIES** since your last visit? ◇ Yes ◇ No **If yes**, please list below:	
ALLERGY TO	**REACTION**

PAIN LEVEL: Please circle the number that best describes your current pain level on the chart below



ACTIVITIES OF DAILY LIVING:

Do you need assistance with any of the following activities?	(1 POINT)	(0 POINTS)
BATHING (Bathe self completely)	◇ No	◇ Yes
DRESSING (Put on clothes)	◇ No	◇ Yes
TOILETING (Get on and off toilet)	◇ No	◇ Yes
TRANSFERRING (Move in or out of a bed or chair)	◇ No	◇ Yes
CONTINENECE (self-control over urination and defecation)	◇ No	◇ Yes
FEEDING (Get food from plate into mouth)	◇ No	◇ Yes

Urinary:

Urinary Incontinence? ◇ YES ◇ NO

If yes, type: _________________

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PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	SEX ☐ M ☐ F	MARITAL STATUS ☐ M ☐ W ☐ S ☐ D ☐ CU	
EMAIL ADDRESS	PHONE # TO BEST CONTACT YOU: ☐ Home ☐ Work ☐ Cell	RELATIONSHIP TO RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other			
EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP		
PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER		NAME OF CUSTODIAL PARENT			
RACE	ETHNICITY ☐ **Latino/Hispanic** ☐ **Other** ☐ **Not Reported/Refused**	LANGUAGE			

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP
EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP	

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other		CO-PAY AMOUNT

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL ☐ OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Tri-County Orthopaedics & Sports Medicine, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

____ ____________________

Signature of patient or patient's representative Date

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X-RAY REQUEST POLICY

It is the policy of this practice that upon request, we will provide you with a copy of your x-rays on a CD disc.

If you need the actual films from your exam, it is always $15.00 for 1-3 sets. For each additional set it is always $5.00. If requesting an older set of films that were not done digitally they are free, but must be returned when you are finished with them. These films which were done in our office are stored for 7 years. After this time period they will be destroyed.

Please be reminded that we need 72 hours to process your request.

Be aware that films not taken in this office are the responsibility of the patient. Please take them with you. They are your property. If left in our facility, they will only be stored for 3 years. After this time period they will be destroyed.

If you are a Worker's Comp patient, please contact your case manager to get authorization for any films to be rendered to you.

If a request for x-rays is submitted. Pick up must be within 30 days otherwise a new request must be submitted.

I acknowledge that I have read the X-Ray Request Policy.

____
Print Name of Patient or Legal Guardian

____ ________________
Signature Date

CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT, HEALTHCARE OPERATIONS & FINANCIAL POLICY

I ___________________________ understand that as part of my treatment, Tri-County Orthopedics
(Patient Name)
originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
- A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
- A source of information for applying diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed and accurate and actual.
- As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
- A means by which an insurance appeal at any stage, may be filed.
- You are responsible to supply our staff with any and all insurance identification card(s) at the time of your appointment. If your insurance carrier requires a referral from your primary doctor, it is you're responsibility to present this to our receptionist prior to your visit, as we cannot bill your insurance company without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full at the time of visit. All co-pays are to be collected prior to your visit.
- Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without a patient payment is subject to immediate collection process. Services that are transferred to a collections status will be subject to a $50.00 service fee per occurrence.
- A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.
- I assign all benefits for my medical services to Tri-County Orthopedics.

I understand Tri-County Orthopedics will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

- I authorize Tri-County Orthopedics to release my medical records to the following **friend** or **family member**:

  Name: ________________________________Relationship:________________________

  Name: ________________________________Relationship:________________________

____
Print Name of Patient or Legal Guardian

____ ________________
Signature Date

TRI-COUNTY ORTHOPEDICS
ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I understand that I am financially responsible to Tri-County Orthopedics ("TCO") for any charges not covered by health care benefits. It is my responsibility to notify TCO of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by TCO and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to TCO. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to TCO for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby assign my rights, title and interest under the medical expense section and/or PIP section of my insurance policy to TCO to bring a lawsuit or arbitration against my insurance carrier(s). This allows TCO to retain an attorney of their choice to filing litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against my insurance carrier, or any other company, against which I may proceed for medical expense benefits.

Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal or state laws.

Authorization to Release Information

I hereby authorize TCO to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, including but not limited to filing arbitration/litigation in TCO's name on my behalf; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from TCO on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

______________________________ ________________________
Patient/Responsible Party Signature Date

____
Print Name Patient/Responsibility