

ORTHOPAEDIC & SPORTS MEDICINE CONSULTANTS, INC.

Please Fill Out Completely

Today's Date _____

DATE OF INJURY _____ WORK RELATED AUTO ACCIDENT PERSONAL INJURY

PATIENT INFORMATION Patient Name: _____ Age: _____ Sex: M/F

Patient Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____ SS#: _____ D O B: _____

Marital Status: Single _____ Married _____ Separated/Divorced _____ Widowed _____ Referred By: Dr _____

RESPONSIBLE PARTY INFORMATION Self (*move to next section*) Spouse _____ Mother _____ Father _____ Other _____

Name: _____ Age: _____ Sex: M/F

Street Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____ SS#: _____ D O B: _____

Marital Status: Single _____ Married _____ Separated/Divorced _____ Widowed _____ Employer: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Insurance Co-Pay Amount: _____

Insured Name: _____ D O B: _____ SS#: _____

Employer's Name: _____ Work #: _____

Secondary Insurance Company: _____ Insurance Co-Pay Amount: _____

Insured Name: _____ D O B: _____ SS#: _____

Employer's Name: _____ Work #: _____

Emergency Contact (not in same house): Name: _____

Address: _____ Phone #: _____

FINANCIAL POLICY

Regardless of insurance benefits, or the designation of some other responsible party above, I understand that I am financially responsible for the fees. If I am covered by Medicare, I understand that if I am provided specific written notice, in advance, that Medicare is not likely to cover a particular visit or procedure, I will be responsible to pay for the procedure or visit if I agree to proceed with that procedure or visit. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed above as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fee (including any legal expenses) and, at the option of the Practice, a reasonable charge for late payment.

At the time of the visit, I understand it is my responsibility to obtain a current referral (if required) and pay any deductibles, co-payments, and coinsurance not covered by the insurance plan or a governmental program. Further, I authorize the Practice to file claims on my behalf for covered services and assign all insurance or other payer benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original.

I have read the Financial Policy of OSMC. My signature indicates that I understand and agree to comply with this Financial Policy.

Signature of Patient or Responsible Party (state relationship)

Date

RELEASE OF INFORMATION

I authorize this physician office or its designate to release any medical information requested by representatives of local, state and federal agencies; insurance companies; my physicians or other organizations or entities as may be required by said representatives to assure continuity of care and billing. I understand that my medical records may be reviewed by a representative of my insurance company and my referring physician. I authorize the Social Security Administration to release to this physician's office information regarding my Medicare entitlement.

Signature of Patient or Responsible Party (state relationship)

Date

ORTHOPAEDIC & SPORTS MEDICINE CONSULTANTS, INC.
Review of Systems and Personal, Family and Social History

Name _____ Age _____ Sex _____ Right or Left Handed? _____

Occupation: _____ Family Physician: _____ Pharmacy: _____

Do You Smoke Cigarettes or Cigars? Yes No Amount _____ Do You Drink Alcohol? Yes No Amount _____

Please List Current Medications and Dosage (include herbs and supplements):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Operations: (Type and Date)

Allergies: (Please List) _____ Are you seeing a specialist? Yes No

If Yes, who? _____

Do you have, or have you had, any of the following conditions? (Please circle)

Fear of confined spaces (Claustrophobia)	Yes	No	Abnormal Bleeding	Yes	No	Anesthesia Problems	Yes	No
Ulcers	Yes	No	Phlebitis / Blood Clot	Yes	No	Respiratory Problems	Yes	No
Heart Attack	Yes	No	Pulmonary Embolism	Yes	No	Rheumatoid Arthritis	Yes	No
Irregular Heart Beat	Yes	No	Stroke	Yes	No	Kidney Problems	Yes	No
Congestive Heart Failure	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Multiple Myeloma	Yes	No	Diabetes	Yes	No	Liver Problems	Yes	No
			Cancer	Yes	No	Seizures	Yes	No

Please list any other serious illness or injury: _____

Do your parents or siblings have a history of any of the following conditions? (If Yes, please list family member relationship)

Stroke _____ Diabetes _____ Arthritis _____ Osteoporosis _____

Hypertension _____ Heart Disease _____ Bleeding Problems _____

Malignant Hypothermia _____ Cancer (incl type) _____

Review of Systems: Do You Have Any of The Following Symptoms?

	Yes	No		Yes	No
Fever			Joint Replacement		
Weight Change Lbs Lost _____ or Gained _____			Muscle Weakness		
Blurred or Double Vision			Deformity of Legs, Feet, Arms, or Back		
Chest Pain			Joint Swelling		
Shortness of Breath			Joint Pain or Stiffness		
Heartburn			Persistent Muscle Pain		
Nausea/Vomiting			Skin Rash		
Numbness			Depression		
Excessive Thirst			Swollen Lymph Glands		

Patient Signature _____ Date _____

Physician Signature _____ Date reviewed: _____ Date reviewed: _____ Date reviewed: _____

ORTHOPAEDIC AND SPORTS MEDICINE CONSULTANTS, INC.
PRIVACY STATEMENT 4/03

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY

Your Privacy is Important to Us

Orthopaedic and Sports Medicine Consultants, Inc. (OSMC) is committed to protecting the information you share with us, and in turn respecting your privacy. This Privacy Statement will explain the type of information we collect, how we use that information and how we protect that information. OSMC reserves the right to change this Privacy Statement at any time and will notify you of any changes as required by law.

Who Will Follow This Notice

This notice describes information about privacy practices followed by our employees, staff and other office personnel.

What Information We Collect

OSMC collects information from you on registration forms, medical history forms, authorizations, consents, and releases. This information can include name, address and social security number, insurance ID number, past, present, family, social and medical history. We collect this information to: 1) Accurately identify you 2) Protect and administer your account 3) Understand your needs 4) Provide you, a guardian, or responsible party with necessary information 5) Provide for your treatment, Receive Payment, and for Healthcare Operations.

What Information We May Disclose

We disclose information of a personal nature to your insurance company during the submission and processing of claims on your behalf, other medical providers such as laboratories, imaging facilities and other non-affiliated healthcare providers involved with your care. This information will be shared on an as-needed basis and only to the extent necessary for continuity of care or as required by law.

Protecting Your Personal Information

OSMC takes the security of your information very seriously and has established security standards and procedures to prevent unauthorized access to patient information. We maintain physical, electronic and procedural safeguards to protect your information. Only authorized personnel within our organization who need to service your account see your information. These individuals are trained to properly handle personal information and must abide by the terms of a confidentiality agreement.

Patient Rights – Patient has the right to receive a copy of the Privacy Statement and / or Notice of Privacy Practices of OSMC and to request an amendment or correction be made to their medical record with the understanding that OSMC reserves the right to deny such request as outlined in the Privacy Policy.

We will adhere to the information policies and procedures described in the current privacy policy. If you have any questions regarding this notice, please contact 513-424-7711 or 1-800-331-2663 and ask for the Administrator.

Acknowledgement:

By my signature, I hereby verify that I have been offered/given a copy of the Notice of Privacy Practices of Orthopaedic and Sports Medicine Consultants, Inc.

Patient / Legal Representative's Signature

Date

Witness

Date