RSZ Orthopaedics

Patient Information *(Please complete ALL sections)*

Revised 03/12

Today's Date: ____/____/_____ ****(Please supply photo ID)**

SS#: _____-____-_____ First: _____ MI: ____ Last: _____Suffix: _____

Mailing Address: _____ City _____ State _____ Zip Code _____

□ Male □ Female **Date of Birth**: ____/____/_____ **Age:** _____ □ Single □ Married □ Other_____

Race: _____ Ethnicity: _____ Preferred Language: □ English □ other: _____ Student: □ Yes □ No

Personal E-mail:_____ **Cell :** (____) ____ -_____ **Home:** (____) ____ -_____

Emergency Contact: _____ Relationship: _____Phone: (____) ____ -_____

Employment Information:

□ Employed □ Retired □ Other_____ Employer Name: _____

Work Phone: (____) ____ -_____ Work Address: _____

How were you referred to RSZ? □ Internet □ Yellow Pages □ Friend/Relative □ Employer □ Other Source _____
□ **Referring Doctor**: _____City: _____ State: ____ Phone: (____) ____ -_____

Pharmacy Name: _____ City: _____ State ____ Phone: (____) ____ -_____

Health Insurance Information (*Please supply ALL insurance cards to receptionist*)

Insurance No. 1

Name/Address of Insurance Co: _____

Member ID: _____ Group #: _____

Policy Holder's/Subscriber Name: _____ Address same as Patient □

Date of Birth: ____/____/_____ Home Phone: (____)-____ -_____ _____

SS#: _____-____-_____ Insurance Start Date: ____-____-_____ _____

(Address if different)

Subscribers Relationship to Patient: □ Self □Parent □Spouse □Other_____

Insurance No. 2 (□ Not Applicable)

Name/Address of Insurance Co: _____

Member ID: _____ Group #: _____

Policy Holder's/Subscriber Name: _____ Address same as Patient □

Date of Birth: ____/____/_____ Home Phone: (____) ____ -_____ _____

SS#: _____-____-_____ Insurance Start Date: ____-____-_____ _____

Subscribers Relationship to Patient: □ Self □Parent □Spouse □Other_____ (Address if different)

Auto or Workers' Compensation Insurance Information □ N/A

Auto Related Injury: □ Yes □ No Work Related Injury □ Yes □ No Date of Injury ____/____/_____ State of Injury ____

If work related; Contact at employer: Name: _____ Phone No.: _____

Approved body part/injury to be treated: _____

How was the injury sustained? _____

Claim #: _____ Adjustor Name: _____

Insurance Co: _____Telephone: _____

Address: _____

Street City State Zip

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Family Physician/Primary Care Provider: _____ □ None

Telephone: (____) ____ -_____ Address: _____

Were you treated at a Hospital/ER/Urgent Care Center for this problem? □ Yes □ No **Date** ___/___/_____

Facility Name: _____ Location: _____ **X-rays taken**: □ Yes □ No_____

Do you have x-rays or other tests with you today (CD, DVD, Films, etc.) □ Yes □ No_____

Have you been seen previously by RSZ Orthopaedics:

□ Dr. Rosenfeld □ Dr. Sharps □ Dr. Gordon □ William Mest, P.A.-C. **Date:** ____/____/_____
(if known)

I authorize release of medical information needed to process insurance company claims.

Signature: _____ Date: _____

(Sign here)

I authorize payment to Orthopaedic Surgery and Sports Medicine Group, P.C. (d/b/a RSZ Orthopaedics) for services provided.

Signature: _____ Date: _____

(Sign here)

(Please sign in both requested areas above)

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*****FOR MEDICARE PATIENTS ONLY*****

Name of Patient/Beneficiary: _____

Health Insurance Claim Number: _____

" I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopaedic Surgery and Sports Medicine Group for any services furnished to me by that physician or supplier. I authorized, any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Medicare Patient/Beneficiary Signature: _____ Date: _____

(Sign here)

Name of Patient/Beneficiary: _____

Health Insurance Claim Number: _____

Medi-gap (secondary insurance to Medicare) Policy Number: _____

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to Orthopaedic Surgery and Sports Medicine Group for any services furnished by physician/supplier. I authorize any holder of Medicare information about me to release to _____ any information needed to determine these benefits payable for related services."

Medi-gap Patient/Beneficiary Signature: _____ Date: _____

(Sign here)

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Financial Policy

The following information will be helpful to you in understanding our billing procedures and payment for services.

Orthopaedic Surgery & Sports Medicine Group (d/b/a RSZ Orthopaedics) requests that you supply us with complete insurance information. We will file your claim with your insurance carrier. If your claim is work related or auto accident related, it is mandatory that you provide us with the Workers' Comp or auto insurance carrier's complete name, address and claim number. We also require your medical insurance information. You are required to assign all insurance payments directly to our office. Should you request your insurance company to pay you directly, you will be required to make full payment at the time of service. You should call your insurance company at the start of treatment to verify if your plan covers x-rays, if needed.

Any portion of your bill, that is denied, and not paid by your insurance carrier will be your responsibility. You are required to pay all co-payments and/or deductibles as required by your insurance policy to RSZ Orthopaedics in a timely fashion. Your insurance coverage is a contract between you and your insurance carrier. It is your responsibility to understand your insurance coverage. However, we will assist you in any way we can to maximize your insurance benefits. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. If the insurance problem cannot be resolved in a timely fashion, we will require you to establish written financial arrangements with us until the insurance is resolved.

Each month you will receive a statement reflecting unpaid insurance and personal balances. Payments for private balances are due within thirty (30) days. If payment on a private balance is not received, we have the right to charge a percentage of interest to your balance to each statement after the initial thirty (30) day period. If you are experiencing difficulty in making payments in full, contact our office to make payment arrangements.

IF YOUR INSURANCE REQUIRES A REFERRAL, IT MUST BE OBTAINED PRIOR TO YOUR VISIT. Insurance companies require a referral at time of service and have strict rules stating treatment is not to be provided without a referral. If referral is not presented at the time of your visit, you will be responsible for payment at the time of service. Likewise, if a claim form is necessary, we are unable to submit your claim without the form.

Checks returned by your bank are subject to a processing fee. If your account is referred for collection, you will be responsible for collection costs of the outstanding balance, together with court costs and reasonable attorneys' fees.

We will provide you with the best medical services that meet the highest professional standards. We firmly believe that a good relationship is based upon understanding and open communication, and it is our desire to avoid any disagreement or misunderstanding over payment for our services.

If you have any questions regarding our policy please contact our Billing Department at (610)993-8037.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.C.

Signature: _____ Date: _____

(Sign here)

Signature of Parent or Guardian of Minor: _____

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Patient Medical History

Name: _____ DOB: __/__/____ Today's Date: _____

Height: _____ (inches) Weight: _____ (pounds) Age: _____

Reason for visit: _____Date of 1st Symptom: _____

Rate your overall pain level today on a scale of 1 to 10 **(10 being severe): _____**

Personal Medical History – Please check all that apply □ **N/A**

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Cancer
- ☐ Diabetes-Type 1 or Type II (circle)
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Stomach Ulcers
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Anxiety
- ☐ Depression
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Gout
- ☐ Liver Disease / Hepatitis
- ☐ Sleep Apnea
- ☐ Seizures/Epilepsy
- ☐ TB

Other: _____ ☐ Yes ☐ No **Any Problems w/ Blood Clotting**

Family History – Please check all that apply □ **N/A**

- ☐ Stroke
- ☐ TB
- ☐ Cancer
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Respiratory Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney Disease

Other: _____ ☐ Yes ☐ No **Family History of Blood Clotting**

Social History – Please check all that apply

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No

Tobacco Use: ☐ Yes ☐ No Tobacco Usage: ___ # pack ___ # day

Former Smoker: ☐ Yes ☐ No Former Dates Smoked: _____

Alcohol Consumption: ☐ Yes ☐ No Alcohol Consumption: ☐ Daily ☐ 1-2x week ☐ 1-2x month

History of Substance Abuse: ☐ Yes ☐ No If yes, please specify: _____

Surgical History - (Please List) or **None:** ☐

Type:	Date:	Performing Provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____

Review of Systems

Are you currently having any problems with any of the following? Please answer all questions

Eyes	☐ Yes ☐ No	Joint aches/pains	☐ Yes ☐ No
Ears	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Nose	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Throat	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Lungs/Breathing	☐ Yes ☐ No	Weight loss _____lbs.	☐ Yes ☐ No
Stomach Problems	☐ Yes ☐ No	Weight gain _____lbs.	☐ Yes ☐ No
Bowel/Bladder Problems	☐ Yes ☐ No	Fever	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Chills	☐ Yes ☐ No
Numbness/Tingling	☐ Yes ☐ No	Other_____	

1. Are you allergic to <u>any</u> Medications ☐ Yes ☐ No (Please specify)

_____

2. Are you allergic to Latex/Neoprene ☐ Yes ☐ No

3. Other allergies ☐ Yes ☐ No (Please specify) _____

4. Are you taking any blood thinners? ☐ Yes ☐ No

☐ Xarelto ☐ Plavix ☐ Coumadin (Warfarin)

☐ Pradaxa ☐ Lovenox ☐ ASA

Current Medication List (Please List All) or None: ☐

Drug Name:	Dose:	Prescribing Provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(*use reverse side or attach list if* needed)

Over the Counter Meds/Herbs/Supplements:_____

I certify that the above information on this and the preceding page is true and correct.

PATIENT/GUARDIAN SIGNATURE: _____

(Sign here)

Reviewed by: _____ Date: _____

(Practitioner Signature)

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Note: Your signature on these forms represents that you have completed this form accurately and completely and have disclosed all information for our staff to treat you in our offices.

ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, PC
KARL ROSENFELD, M.D., F.A.C.S. LEWIS S. SHARPS, M.D., F.A.C.S. STUART L. GORDON M.D.

WILLIAM L. MEST, PA-C

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 Orthopaedics Surgery & Sports Medicine Group, P.C. (d/b/a RSZ Orthopaedics) may not use or disclose your health information, except as provided in the Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to this office.

AUTHORIZATION SECTION PLEASE COMPLETE ALL SECTIONS

I, _____ (print name) **Date of Birth:** ___/___/_____ hereby authorize the use and disclosure if the following health information that pertains to me. I approve sensitive information to be disclosed including but not limited to AIDS, HIV infection, Psychiatric Care/psychological assessment, treatment for drug and alcohol, ADHD/ADD – I can revoke this in writing at any time and address it with the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to the information already released in response to the authorization.

Orthopaedic Surgery & Sports Medicine Group, PC

I have received/read the HIPAA privacy notice or read such document and privacy information as required by law.
I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the practice. I future understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
I understand that this authorization will automatically expire one year from the last date of service seen by this practice.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Description of Representative's Authority **Signature of Witness**

I authorize ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, PC to make these disclosures of my health information:

You have the right not to disclose specific records per the below information. If you authorize all of the items in the box to be disclosed:
□ ALL ITEMS

I authorize the following person(s) to receive these disclosures of my health information:

_____ _____

Name(s) **Relationship(s)** **Date**

Office locations:
Paoli: 254 W. Lancaster Ave, P.O. Box 968, Paoli, PA 19301 (610)644-7755 FAX (610)644-8290
Phoenixville: 826 Main St., Suite 302, Phoenixville, PA 19460 (610)644-7755 FAX (610)644-8290
Limerick: 420 Linfield-Trappe Rd. Building A, Suite 2000, Limerick, PA 19468 (610)495-0099 FAX (610)495-2543
Bala Cynwyd: 100 N. Presidential Blvd, Pagoda Building, Bala Cynwyd, PA 19004 (610)644-7755