

Commonwealth Orthopaedics Registration Information 2010

Patient Information

| | |
|--|--|
| Patient Name Account # _____ _____ Social Security Number _____ | Home Telephone # _____ Work Telephone # _____ |
| Address | Cell Telephone # _____ |
| City, State & Zip Code | Patient Sex ___Male ___Female |
| FOR MEDICARE PATIENTS ONLY: Do you currently reside in a Skilled Nursing Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO | Date of Birth Age _____ _____ |
| Employment/Student Status: ___Full time employed ___Full time student ___Part time employed ___Part time student ___Unemployed ___Retired | Employer Name & Address _____ _____ _____ |
| Referring Physician _____ Family Physician | Email Address (please print) _____ Married ____ Single ____ Other ____ |

Financially Responsible Person (if different from above)

| | |
|---|---|
| Full Name _____ Address _____ City, State & Zip Code _____ Date of Birth _____ | Social Security Number _____ Home Telephone # _____ Work Telephone # _____ Cell Telephone # _____ |
| Employer Name _____ | Relationship to the Patient (circle one) Self Spouse Child Parent Other |

Insurance Company Information

| | |
|---|---|
| Primary Insurance Company Name | Secondary Insurance Company Name |
| Address, City, State & Zip | Address, City, State & Zip |
| Policy Holder Date of Birth | Policy Holder Date of Birth |
| Policy Holder Employer Policy Holder SSN | Policy Holder Employer Policy Holder SSN |
| Policy Number Group Number | Policy Number Group Number |
| Relationship to the Patient (circle one) Self Spouse Child Parent Other | Relationship to the Patient (circle one) Self Spouse Child Parent Other |

Date Reviewed _____ Initials _____

Appointment Information:

Patient Name: _____ Account#: _____

Name of Physician to see today: _____

Name of Physician who referred you here today: _____

Body Area being seen for today: _____

| | | | |
|---------------|-----|--------------------|-------------------------------|
| Problem? | Y N | Date problem began | _____ |
| Injury? | Y N | Date of Injury | _____ |
| Work Injury | Y N | Date of Injury | _____ |
| Auto Accident | Y N | Date of Accident | _____ State of Accident _____ |

Emergency Contact Information:

Name _____ Telephone Number _____

Relationship to patient _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Commonwealth Orthopaedics and Rehabilitation, PC, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

If you are covered by Medicare, please read and sign the following:

In Medicare cases, Commonwealth Orthopaedics and Rehabilitation, PC, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature _____ Date _____

Patient Medical History

| | |
|--|--|
| Patient Name: _____ Date _____ Age: _____ Height _____ Weight _____ | Office Use Only BP _____ P _____ R _____ T _____ |
|--|--|

Chief Complaint: Pain Numbness Weakness Stiffness Swelling Popping/Grinding Unstable
 Other _____

Body Part Affected: Right Left _____

Date of injury or onset of symptoms _____

Where did the injury/symptoms occur? at home at work during sports/recreational car accident at school
 Other _____

How did the injury/symptoms occur? sudden/traumatic lifting/bending gradual onset injury relating to a fall
 recurrence of previous injury Other _____

Allergies: No known allergies Latex Soy Eggs Penicillin Sulfa Iodine Shellfish Radiological dyes
 Other _____

Current Medications: None

List prescription and non-prescription medications, including vitamins, herbal and nutritional supplements.

| Medication | Dose | How Often | Medication | Dose | How Often |
|------------|-------|-----------|------------|-------|-----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Review of Systems: (Check all that apply)

General: NONE Excessive fatigue Weakness Fever Exercise intolerance Other _____

Eye Problems: NONE Blurred vision Double vision Cataracts Glaucoma Light sensitivity
 Glasses/Contacts Other _____

Ears, Nose, Throat, Mouth: NONE Difficulty swallowing Nose bleeds Sore throat Ear pain Seasonal allergies
 Hard of hearing Other _____

Cardiovascular: NONE High blood pressure Heart attack Chest pain Palpitations Blood clots
 Murmur Other _____

Respiratory: NONE Shortness of breath Asthma Sleep apnea chronic cough wheezing
 Other _____

Stomach/Intestinal: NONE Heartburn Nausea Vomiting Abdominal pain Gallbladder problems
 Other _____

Kidney/Bladder: NONE Painful urination Frequent urination Incontinence Frequent bladder infection
 Enlarged prostate Other _____

Musculoskeletal: NONE Muscle cramps Joint stiffness Joint pain Joint swelling Other _____

Skin Problems: NONE Itching Excessive dryness Hives Dermatitis Other _____

Neuro/Psychological: NONE Anxiety Depression Headaches Memory loss Seizures ADD/ADHD
 Other _____

Endocrine Problems: NONE Weight gain Weight loss Diabetes Thyroid problems Gout Liver problems
 Other _____

Hematologic: NONE Bruise easily Prolonged bleeding Anemia Other _____

Reproductive: NONE Pelvic pain Heavy Bleeding Cysts Other _____

If female, are you pregnant? Yes No Date of last menstrual period: _____

Financial Policy

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable copay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. Furthermore, if you do not pay your copay at the time of your appointment, we retain the right to levy an administrative charge of \$20. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance requires prior to your visit.

If you do have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. In addition to the principal balance due, you will also be responsible for any legal or collection agency fees incurred. Any payment made to us in the form of a check that is returned for insufficient funds will incur a \$25 fee per incidence.

Cancellation Policies

Physician Offices: If you fail to provide us with a 24 hour notice of cancellation or fail to keep your scheduled appointment, we reserve the right to charge you a \$30 no show fee.

Physical Therapy: If you fail to provide us with a 24 hour notice of cancellation, you will be charged a \$30 cancellation fee. If you are unable to keep your scheduled appointment and do not notify us, you will be charged a \$50 no show fee. If you schedule an initial evaluation appointment and fail to keep the appointment, you will be charged a \$130 fee.

Surgery: If you fail to provide us with at least 7 (seven) days notice of cancellation or fail to keep your scheduled surgery, we reserve the right to charge you a \$250 fee.

Surgery Policies

If you have surgery performed in one of Commonwealth's outpatient surgery centers, you will receive three separate charges for the services provided: one for the surgeon's fee, one for the facility, and one for the anesthesiologist. If you have surgery in an outside facility (a hospital or non-Commonwealth surgery center), you will receive a bill from us representing the surgeon's fee. In addition, you likely will receive separate bills for services rendered by the hospital, anesthesiology, and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

Durable Medical Equipment

There may be occasions when your course of treatment requires the use of an orthopaedic appliance or soft goods to facilitate your rehabilitation. In these instances, we will verify your benefits and file a claim to your insurance company when applicable. In cases where insurance does not cover the required equipment we do require payment in full for the equipment at the time of service.

Consent

My signature below indicates my full understanding and consent to the above described policies. Additionally, I provide authorization to my insurance company to pay any applicable benefits directly to Commonwealth Orthopaedics & Rehabilitation, P.C.

Patient signature

Date

Guarantor signature (if guarantor is not patient)

Date

Acknowledgment of Notice of Privacy Practices and Permission of Disclosure

I acknowledge that I was made aware of Commonwealth Orthopaedic's Privacy Policy and a copy was available for my review.

I authorize the following person(s) access to my protected health information (PHI).

| Name | Date of Birth |
|-------|---------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| Patient Printed Name | Date |
|----------------------|------|
|----------------------|------|

Patient Signature

Printed Name of Personal Representative

Signature of Personal Representative

Relationship of Personal Representative to Patient

Notice of Disclosure of Ownership Interest

Commonwealth Orthopaedics & Rehabilitation, P.C. (Commonwealth Orthopaedics) is wholly owned by a subset of the physicians who provide care in the offices of Commonwealth Orthopaedics. The same group of physician owners also owns the outpatient surgery centers and physical therapy clinics associated with Commonwealth Orthopaedics. Because the physicians own the surgery centers and physical therapy operations, they are best able to ensure the highest level of care is provided to you. A schedule of fees related to the services you might receive can be provided at your request. You have the right to request that services be provided at locations other than those described above.

By my signature below, I am acknowledging this Notice of Disclosure of Ownership Interest on the date set forth below.

Patient Signature

Date

Patient's Agent/Representative

Relationship to Patient