# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

| | | |
|---|---|---|
| FIRST NAME: MIDDLE INITIAL: | LAST NAME: | SEX: ☐ MALE ☐ FEMALE |
| DATE OF BIRTH: | SOCIAL SECURITY: | EMAIL: |
| HOME ADDRESS: APT. # | CITY: STATE: | ZIP CODE: |
| HOME PHONE #: | MOBILE #: | WORK #: |
| EMPLOYER / SCHOOL:<br>FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____ | EMPLOYER ADDRESS: | PATIENT PREFERRED COMMUNICATION:<br>☐ HOME PHONE ☐ MOBILE PHONE<br>☐ MAIL TO HOME ADDRESS OF FILE |
| OCCUPATION:<br>MARITAL STATUS:<br>SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED ____ | RACE:<br>☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE<br>☐ ASIAN ☐ AMERICAN INDIAN / ALASKAN NATIVE<br>☐ BLACK / AFRICAN AMERICAN | ETHNICITY:<br>☐ HISPANIC / LATINO<br>☐ NON-HISPANIC / LATINO<br>PRIMARY LANGUAGE: |

AUTHORIZED PHONE NUMBER TO LEAVE A MESSAGE: (_____) _____ PATIENT/PARENT/GUARDIAN SIGNATURE: _____

## EMERGENCY CONTACT INFORMATION

| | | | |
|---|---|---|---|
| PRIMARY CONTACT: | RELATIONSHIP TO PATIENT: | HOME PHONE: | WORK / OTHER PHONE: |

## IF PATIENT IS A MINOR, PLEASE PROVIDE US WITH THE INFORMATION BELOW:

MOTHER (LEGAL GUARDIAN): _____ DATE OF BIRTH: _____ MOBILE #: _____

FATHER (LEGAL GUARDIAN): _____ DATE OF BIRTH: _____ MOBILE #: _____

## GUARANTOR / RESPONSIBLE PARTY INFORMATION

| | | |
|---|---|---|
| FIRST NAME: | LAST NAME: | MIDDLE INITIAL: |
| DATE OF BIRTH: | SOCIAL SECURITY: | SEX: |
| HOME ADDRESS: APT. # | CITY: STATE: | ZIP CODE: |
| HOME PHONE #: | MOBILE: | WORK #: |
| EMPLOYER / SCHOOL:<br>OCCUPATION:<br>FULL TIME ____ PART TIME ____ RETIRED ____ STUDENT ____ | EMPLOYER ADDRESS: | RELATIONSHIP TO PATIENT:<br>SELF _____ SPOUSE _____ PARENT _____ OTHER _____ |

## PRIMARY INSURANCE INFORMATION

| | | |
|---|---|---|
| INSURANCE COMPANY: | GROUP NAME OR NUMBER: | INSURANCE / MEMBER ID NUMBER: |
| RELATIONSHIP TO POLICY HOLDER:<br>SELF _____ SPOUSE _____ CHILD _____ OTHER _____ | POLICY HOLDER LAST NAME:<br>SEX: DATE OF BIRTH: | FIRST NAME: INITIAL:<br>PHONE: |
| ADDRESS: | CITY: | STATE: ZIP CODE: |

## SECONDARY INSURANCE INFORMATION

| | | |
|---|---|---|
| INSURANCE COMPANY: | GROUP NAME OR NUMBER: | INSURANCE / MEMBER ID NUMBER: |
| RELATIONSHIP TO POLICY HOLDER:<br>SELF _____ SPOUSE _____ CHILD _____ OTHER _____ | POLICY HOLDER LAST NAME:<br>SEX: DATE OF BIRTH: | FIRST NAME: INITIAL:<br>PHONE: |
| ADDRESS: | CITY: | STATE: ZIP CODE: |

| | | |
|---|---|---|
| WHO REFERRED YOU TO OUR OFFICE? | | PHONE: |
| ADDRESS: | CITY: STATE: | ZIP CODE: |

| | | |
|---|---|---|
| WHO IS YOUR PRIMARY CARE DOCTOR? | | PHONE: |
| ADDRESS: | CITY: STATE: | ZIP CODE: |

## YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT FOR ANY SERVICES RENDERED

### FINANCIAL POLICY

Charges for medical services are due and payable at the time the services are rendered. As a courtesy to our patients we file their insurance claims. You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our Patient Account Representatives. This will avoid misunderstandings and enable you keep your account in good standing. Charges for medical care rendered by this office will be through this office and should not be confused with charges of care received in the hospital

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### RELEASE

I authorize assignment of benefits to Acute Orthopedic Care Specialists, LLC. I also give authorization to release necessary information and for Acute Orthopedic Care Specialists, LLC to receive medical records from whomever necessary. I understand that I am financially responsible for all charges.

**I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**

## MEDICAL SERVICES AGREEMENT

This Agreement is entered into between Envision Physician Services ("Medical Provider") and the undersigned ("Patient"). The purpose of this Agreement is to make Patient eligible for a discount and to help you make an informed decision as to whether or not you wish to receive Medical Services that you knowingly will have to pay for yourself. In exchange for Patient's agreement to directly pay Medical Provider, its agents and/or assigns for any and all medical treatments, procedures, services, prescriptions and/or products ("Medical Services") which may be delivered and/or prescribed by Medical Provider, Patient represents, understands, acknowledges and agrees to the following:

1. ***Any and all Medical Services to be provided under this Agreement are not covered under any public or private health insurance program. Patient shall be wholly responsible for the payment of any and all costs due and/or that may become due pursuant to this Agreement and in any way related to such Medical Services.*** Patient shall not to submit a claim, bill to or seek reimbursement from any public health program (i.e. Medicare, Medicaid, Tricare, Veterans Affairs and Federal Benefits) or any private health insurance plan or worker's compensation plan for any item or service received pursuant to this Agreement. Patient shall not appeal any determinations that public health program, private health insurance plan, or worker's compensation plan will not pay for any item or Medical Services received hereunder.

2. Medical Provider may, but is not required to, offer discounted fees or similar incentives to Patient from time-to-time depending on financial hardship and/or lack of public and/or private health insurance, without changing the Patient's liability for the Medical Services, costs and/or fees incurred hereunder, it being explicitly agreed that Medical Provider is under no obligation to extend such other discounted fees or incentives to Patient. Medical Provider has sole discretion as to who receives discounts, the amounts of discounts, when discounts are issued and all other issues related to the issuance of discounts. Medical Services.

3. Independent entities and individuals will have their own billing and collection practices that are not covered by this Agreement. The fees and/or costs for Medical Services does not include the costs of any prescription medicines or other treatment, procedure, service or product provided by separate independent entities or individuals that may be prescribed or recommended by Medical Provider in connection with Medical Services. Patient may receive one or more separate bills for such prescription medicines and other treatments, procedures, services or products and is wholly responsible for payment of such cost.

4. It is the Patient's responsibility to provide Medical Provider with accurate and complete medical records, history and descriptions of the Patient or covered family member's condition and physical well-being. To the extent that information provided is not accurate and complete, the Medical Services provided hereunder may be materially affected and Patient assumes any risk, and takes full responsibility and waives any claims against Medical Provider for personal injury, death or damages as a result and agrees to the extent permitted by applicable law to defend, indemnify and hold harmless Medical Provider from and against any and all claims of any nature including all costs, expenses and attorneys' fees, which in any manner result from inaccurate or incomplete information provided by Patient or its authorized representative. Patient shall be responsible for the costs of copying any medical records necessary to provide Medical Services under this Agreement.

5. Patient and its covered family members shall not assign this Agreement, nor its right, title or interest herein assigned, transferred, conveyed, sublet or otherwise disposed of without the express written consent of Medical Provider and any attempts to assign this Agreement without written consent are null and void. Medical Provider will not necessarily be the provider of services under this Agreement and Patient may be provided services under this Agreement by a contracted professional medical individual or entity. Medical Provider may delegate responsibilities related to this Agreement to one or more independent contractors. No provision of this Agreement shall be construed to confer any third-party beneficiary rights to any non-party other than covered family members.

6. Medical Provider shall not be deemed in violation of any provision of this Agreement if it is prevented from performing any of its obligations by reason of: (a) severe weather, storms, earthquakes or other natural occurrences; (b) strikes or other labor unrest; (d) power failures; (e) nuclear or other civil or military emergencies; (f) acts of legislative, judicial, executive, or administrative authorities; or (g) any other circumstances that are not within its reasonable control. This Section shall not apply to obligations imposed under applicable laws and regulations.

7. Any provision of law or regulation or judicial or administrative interpretation of same that invalidates, or otherwise is inconsistent with the terms of this Agreement that, in the reasonable judgment of either party, would cause one or both parties to be in violation of law or regulation shall be deemed to have suspended the terms of this Agreement; provided, however, that the parties shall exercise reasonable efforts to accommodate the terms and intent of this Agreement consistent with the requirements of law and regulations. If any part, term or provision of this Agreement is held by a court of competent jurisdiction to be illegal or unenforceable, the remaining portions or provisions of this Agreement shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Agreement did not contain the particular part, term or provision held to be invalid, unless to do so would contravene the present valid and legal intent of the parties.

8. This Agreement shall be enforced and construed in accordance with the laws of the State in which Medical Services are provided. Jurisdiction of any litigation with respect to this Agreement and/or Medical Services shall be venued in a court of competent jurisdiction in the State and County in which the Medical Services were provided. The only information released shall be the minimum necessary. In any action, declaratory or otherwise, arising out of this Agreement, the prevailing party shall be awarded reasonable attorney's fees and related costs to be paid by the other party.

9. This Agreement, including any exhibits or schedules annexed hereto, constitutes the entire understanding and agreement between the Parties with regard to all matters herein. There are no other agreements, conditions or representations, oral or written, express or implied, with regard thereto. This Agreement supersedes any and all previous agreements, whether oral or written, between the Parties concerning the subject matter hereof.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ANY AND ALL OF ITS TERMS.**

**PATIENT NAME (PRINT): _____**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**

## HISTORY OF PRESENT ILLNESS

| | |
|---|---|
| What was your date of injury? | Please rate your current pain level (0 – None to 10 – Worst) |
| What part of your body was injured? | What makes your symptoms worse? |
| How did your injury occur? | What makes your symptoms better? |
| Please describe your symptoms | What treatment, if any have you previously received for this injury? |

## PAST MEDICAL / SURGICAL HISTORY

| Please list all of your current or previous medical problems | Please list any surgeries that you have had: | |
|---|---|---|
| | Date | Surgery |
| | | |
| | | |
| | | |
| | | |
| | | |

## REVIEW OF SYSTEMS

**Have you been diagnosed or received treatment for any of the following?**

| Constitutional | Y | N |
|---|---|---|
| Fever | | |
| Weight loss/gain | | |
| Unusual Fatigue | | |
| **Eyes** | **Y** | **N** |
| Poor Vision | | |
| Eye pain | | |
| Tearing | | |
| Redness | | |
| **Ears, Nose, Throat** | **Y** | **N** |
| Hearing loss | | |
| Nasal Congestion | | |
| Cough | | |
| **Gastrointestinal** | **Y** | **N** |
| Upset Stomach | | |
| Diarrhea | | |
| Constipation | | |
| Ulcers | | |
| Reflux | | |
| **Female** | **Y** | **N** |
| Pregnant | | |
| Nursing | | |

| Muscles, Bones, Joints | Y | N |
|---|---|---|
| Joint Pain | | |
| Stiffness | | |
| Swelling | | |
| Cramps | | |
| Rheumatoid arthritis | | |
| **Skin** | **Y** | **N** |
| Wounds | | |
| Rash | | |
| Pimples | | |
| **Neurological** | **Y** | **N** |
| Numbness | | |
| Paralysis | | |
| Seizures | | |
| **Endocrine** | **Y** | **N** |
| Diabetes | | |
| Hypothyroidism | | |
| Hyperthyroidism | | |
| **Genitourinary** | **Y** | **N** |
| Frequent infections | | |
| Incontinence | | |
| Night time frequency | | |

| Cardiovascular | Y | N |
|---|---|---|
| High blood pressure | | |
| Chest pain | | |
| Irregular heart beat | | |
| **Respiratory** | **Y** | **N** |
| Congestion | | |
| Wheezing | | |
| Shortness of Breath | | |
| **Psychiatric** | **Y** | **N** |
| Anxiety | | |
| Depression | | |
| Difficulty Sleeping | | |
| **Blood /Hematology** | **Y** | **N** |
| Bleeding | | |
| Anemia | | |
| Reaction to transfusion | | |
| High cholesterol | | |
| **Allergy / Immunology** | **Y** | **N** |
| Hives | | |
| Itching | | |
| Sneezing | | |
| Lupus | | |

## SOCIAL HISTORY

| Occupation: | Y | N | | |
|---|---|---|---|---|
| Do you smoke cigarettes or use tobacco products? | | | How many years have you smoked? | How many packs do you smoke per day? |
| Do you drink alcohol? | | | How much alcohol do you drink? | How often do you drink alcohol? |
| Do you use illicit drugs? | | | What drugs do you use? | When was the last time you used drugs? |

## FAMILY HISTORY

| | Self | Father | Mother | Sibling | Grandparents | Other |
|---|---|---|---|---|---|---|
| Diabetes | | | | | | |
| Arthritis | | | | | | |
| Hypertension | | | | | | |
| Heart Disease | | | | | | |
| Stroke | | | | | | |
| Cancer | | | | | | |
| Thyroid Disease | | | | | | |
| Bleeding Disorder | | | | | | |

## PATIENTS REQUIRING ASSISTANCE FOR MOBILITY, COMMUNICATION OR COMPLETION OF PAPERWORK

For your safety and the safety of our employees, office staff will not be able to move any non-ambulatory patients. If you are not able to self-transfer, someone that can assist you will need to stay with you for your appointment. If there is no one that can stay, your appointment will need to be rescheduled.

If a patient is not able to fully understand their plan of care, a family member or facility employee MUST stay with the patient for the duration of the appointment.

If a patient is not able to sign their paperwork and a family member is signing on behalf of them, we MUST have a copy of the medical POA for their chart. This can be brought at the next scheduled appointment, mailed or faxed but again, we MUST have this for the chart.

Thank you for your understanding and we apologize for any inconvenience.

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____** **DATE: _____**

## NOTICE OF PRIVACY PRACTICES

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes:

- **TREATMENT**
  This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT**
  This means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS**
  This includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually Identifiable information. We may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternate locations.
The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

**PATIENT NAME (PRINT): _____**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**

## CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the "Notice of Privacy Practices" of Acute Orthopedic Care Specialists, LLC (AOCS) and have had all questions answered by this office. I also consent to the use/and or disclosure of my protected health information by AOCS for the following purposes:

- **TREATMENT**
  It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.
- **PAYMENT**
  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for billing personnel including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.
- **HEALTHCARE OPTIONS**
  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

**PATIENT NAME (PRINT): _____**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____ , hereby authorize Acute Orthopedic Care Specialists, LLC to use and/or disclose my protected health information (PHI) to the following persons:

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

This PHI is being used or disclosed for the following purposes:

Providing appointment reminders
Describing or recommending treatment alternatives
Providing information about health-related benefits and services that may be of interest to the individual

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that I have the right to refuse to sign this authorization and that my treatment or eligibility for benefits will not be conditioned upon this authorization. The use or disclosure requested in this authorization may result in direct or indirect compensation to Acute Orthopedic Care Specialists, LLC from a third party.

**PATIENT NAME (PRINT): _____**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**

## CONTROLLED SUBSTANCE POLICY

Controlled substances include opioid pain relievers (Codeine, Vicodin, Lortab, Norco and others), as well as anxiety medications (e.g. Klonopin and Xanax). Controlled substances are "controlled" for good reason. Abuse of these medications is widespread. Taking narcotics for more than a few weeks may lead to addiction, which can be a severe problem. Prescriptions of these medications are strictly supervised by the Drug Enforcement Agency (DEA), and our licenses are at risk if we prescribe them without compelling reasons. For this reason, we have enforced the following policy.

1. We prescribe narcotics for a MINIMUM of 14 days, MAXIMUM of 6 weeks.
2. You may only fill at ONE PHARMACY, switching pharmacies is not allowed.
3. All medications must be approved by the physician. For this reason, please allow 48-72 hours for all medication refills.
4. As surgeons, we generally do not prescribe medications for anxiety. We do not refill such prescriptions written by other physicians. This is the responsibility of your primary care physician, psychiatrist, or other prescribing doctor.
5. We do not refill or replace any lost, forgotten, stolen or any other prescriptions that have become unavailable in any other way.
6. We have a strict policy AGAINST prescribing controlled substances on night and weekends. If you have severe pain at night or during the weekend, you should go to the nearest emergency room to seek treatment.
7. We do not prescribe medications because another physician is unavailable at the time, "just to tie me over." There is always a covering physician.
8. Tylenol works very well for pain. If you are allergic to Tylenol, have liver problems, or if you think it "doesn't even touch it", we will still not prescribe narcotics, but look for other alternatives.
9. If you need narcotic pain medications longer than 6 weeks, you will be referred to a pain management clinic.

I, _____, understand that by signing below, I have read and agree with the rules and regulations of Acute Orthopedic Care Specialists and agree to abide by such rules and regulations.

**PATIENT NAME (PRINT): _____**

**SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____ DATE: _____**