NORTHEAST
ORTHOPEDICS AND SPORTS MEDICINE

Patient Information

Patient Name: _____Date of Birth: _____Marital Status:_____

Address: _____ Apt # _____ SS#: _____-_____-_____

City: _____ State: _____ Zip: _____ Home #: _____

Email: _____ Cell #: _____
May we email you with informational materials? Yes ____ No _____

Primary Language: _____ Race: _____ Ethnicity: _____ Gender: Male Female

Employer: _____ Work #: _____

Occupation: _____

Primary Care Doctor: _____ Phone #:_____,

Referring Doctor: _____ Phone #:_____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____ City _____ State _____ Zip _____

Emergency Contact Information

Name: _____ Relationship _____ Phone _____

Insurance Information

Primary Insurance Name: _____

ID/Policy #: _____

Insured Name: _____ Relationship to Patient: _____

Insured Date of Birth: _____ Insured SS#: _____

Secondary Insurance Name: _____

ID/Policy #: _____

Insured Name: _____ Relationship to Patient: _____

Insured Date of Birth: _____ Insured SS#: _____

If patient is a minor who is responsible for bills: _____

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Patient Name: _____ **Birthdate**: _____
(Print Name)

Are you currently a resident in a Skilled Nursing Facility? ____ Yes ____ No. If yes date of admission _____

Name and address of Skilled Nursing Facility:
_____

HIPAA

I have read the Notice of Privacy for Northeast Orthopedics & Sports Medicine: _____
Signature

There are very strict governmental mandated rules concerning patient confidentiality and release of a patient's medical information. Therefore, in our continuing efforts to improve patient/physician communication, additional ways to receive information, with your signed authorization, concerning your care and treatment, can be offered.

May we leave a message on your:

Home phone: Yes No initial_____
Cell phone: Yes No initial_____

How would you like us to contact you to confirm your appointments? Text _____ Home phone _____

Is there any Family Member or Friend with whom we may discuss or to whom we may release information and/or prescriptions on your behalf? No Initial_____
Yes, See Below:

	Name	Relationship	Phone #
1.	_____		
2.	_____		

I understand I may revoke or change this authorization at any time in writing.

_____ _____
Signature Date

Assignment of Insurance Benefits – I hereby authorize direct payment of Medical/Surgical benefits to Northeast Orthopedics & Sports Medicine for services rendered. I understand I am financially responsible for any balances not covered by my insurance.

Medicare – I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Authorization to release information – I hereby authorize Northeast Orthopedics & Sports Medicine to release any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefits.

Patient/Parent/Guardian: _____ _____
Signature Date

ePrescription Consent Form

I agree that Northeast Orthopedics and Sports Medicine, PLLC may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

_____ _____
Patient Signature (or Legal Representative) Date
☐ Patient refused to sign

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Financial Policy

We are pleased that you have chosen this practice for your medical care. We are committed to providing you with the best possible treatment. The following is a statement of our financial policy, which we ask that you read prior to any treatment. If you have any questions about our fees, our financial policy, or our mutual responsibilities, please ask our billing department.

Insurance

Due to rapid changes taking place in the health insurance industry, it is imperative that you are aware of the benefits and requirements of your insurance plan. It is your responsibility to advise us of your plan in advance, each and every time we provide you service. **Please be advised that if we have not been informed of your program's requirements and if we provide medical treatment, you will be responsible for the fee.**

Part of the services provided may be your financial responsibility. Any monies applied to your annual deductible, copayments and co-insurance are always the patient's responsibility.

The Patient hereby agrees that in the event that their insurance company does not make payment for any reason the patient will be responsible for payment of the charges for any and all treatment rendered to that patient. In the event that the patient is billed by Northeast Orthopedics and Sports Medicine and the patient does not pay either after payment was denied by the insurance company, or, if there is no insurance coverage, then Northeast Orthopedics and Sports Medicine will be entitled to Collection costs of 35% plus any expenses required to collect the monies owed by the patient for the treatment, services and/or charges for the patient.

Referral Policy

It is the patient's responsibility to know if he/she needs a referral from his/her Primary Care Physician. If your insurance plan requires a referral and you did not obtain one you will be asked to reschedule your appointment or sign a financial waiver that you will be held financially responsible for all charges incurred at your appointment. It is the patient's responsibility to know if their insurance plan has changed and must provide our office with the new insurance card.

Payment

We accept Cash/Check/Credit Card as forms of payment. A service charge will be made for all returned checks. Payment for services are due at the time of your visit. Co-payments, Co-insurance and deductibles are to be paid in full at the time of visit.

Practitioner Disclosure of Ownership

In accordance with State and Federal requirements I have been advised that the Physicians of Northeast Orthopedics and Sports Medicine maintain a financial interest in SurgiCare Surgical Associates of Mahwah, Rockland and Bergen Surgery Center, White Plains Surgery Center, Ramapo Valley Surgery Center and Northeast Orthopedics and Sports Medicine Physical Therapy. I understand and have been informed of my option to seek treatment at another facility of my choice. I also understand that if I elect to receive services at this facility it may be an out-of-network facility. I understand that by electing to utilize an out of network facility, insurance re-imbursement for services and facility fees may be on an out of network basis, and that I may have out-of-pocket expenses not covered by my insurance for which I may be personally responsible.

I have read the financial policy. I understand and agree to this financial policy.

_____ _____

Signature Date

NORTHEAST

Medical History Form

Name _____ Birth Date _____ Gender: M F

Occupation _____ Height _____ Weight _____ Handedness: R L

Primary / Referring MD _____ Pharmacy & city _____

Reason for visit _____ Date of onset _____

Is this: ☐ Work Related ☐ Car accident ☐ Previously evaluated or treated

Medical History

☐ **No medical problems**

☐ High blood pressure
☐ Heart attack
☐ Coronary Artery Disease
☐ High cholesterol
☐ COPD

☐ Asthma
☐ Osteoarthritis
☐ Lyme Disease
☐ Rheumatoid arthritis
☐ Gout

☐ Lupus
☐ Thyroid disease
☐ Diabetes
☐ Reflux (GERD)
☐ Ulcers

☐ Blood clot (DVT/PE)
☐ Cancer(type)_____
☐ Depression
☐ Anxiety
☐ Stroke

☐ Renal failure
☐ Sleep apnea
☐ Osteoporosis

☐ Other: _____

Have you recently experienced any of these symptoms:

☐ **No recent symptoms**

General
☐ Fever
☐ Chills
☐ Weight Gain/Loss
☐ Rash

Cardiovascular
☐ Chest Pain
☐ Palpitations

Respiratory
☐ Short of breath
☐ Cough

Musculoskeletal
☐ Neck Pain
☐ Back Pain
☐ Joint Pain
☐ Muscle Pain

Gastrointestinal
☐ Abdominal pain

Endocrine
☐ Excessive thirst

Hematologic Oncologic
☐ Bleeding tendency
☐ Easy bruising

Head and Neck
☐ Headaches
☐ Nosebleeds
☐ Sore throat

Urinary/Gyn
☐ Blood in urine
☐ Loss of bladder control
☐ Are you pregnant

Social Do you:
☐ Smoke Cig. (__packs / day)
☐ Quit smoking (/ /)
☐ Drink Alcohol (__Drinks / week)
☐ Quit drinking (/ /)
☐ Have a history of substance abuse
☐ Use or have used smokeless tob.

Did you have a flu shot in the past year? Y (Date / /) N (circle one)

Medications (dose / frequency) ☐ **none**

Surgeries (procedure / Year) ☐ **none**

Allergies (medication / reaction) ☐ **none**

Family History (disease / relationship) ☐ **none**

_____

Patient/Guardian Signature Date

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VISIT DETAILS

Patient Name:_____Acct #:_____Date:_____

What part of your body is being examined today?_____

Were you injured in an Auto or Work related Accident?_____ If yes date of accident_____

When did your symptoms first appear?_____

Have you seen or spoken to another Doctor for this problem? Yes No

If yes please give Doctor's name and address:_____

Date of last appointment:_____ Doctor's Phone Number:_____

Did you have any X-rays, Lab work, MRI, CAT scan Etc… for this injury? Yes No

If yes, What tests were done?_____

When was the test done:_____Where was the test done:_____

In the last 12 Months have you had Physical Therapy or Occupational Therapy: _____

Please give a brief description of your current symptoms (if you were injured in an accident please give accident details)

_____

_____

_____

_____

Please let us know how you heard about us: Doctor Hospital Friend Other:_____

Phone Book: Verizon or Yellow Book **Internet**: Verizon Super Pages Yahoo Google

_____ _____

Patient/Parent/Guardian Signature Print Name