



# 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: \_\_\_\_\_

# NORTHEAST

ORTHOPEDICS AND SPORTS MEDICINE

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 #
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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 or 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

# ORTHOPEDECS AND SPORTS MEDICINE

## 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-imbusement 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.**

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Signature

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Date

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

*Have you recently experienced any of these symptoms:*

**No medical problems**

**No recent symptoms**

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

- General**
- Fever
  - Chills
  - Weight Gain/Loss
  - Rash

- Hematologic  
Oncologic**
- Bleeding tendency
  - Easy bruising

- Asthma
- Osteoarthritis
- Lyme Disease
- Rheumatoid arthritis
- Gout

- Cardiovascular**
- Chest Pain
  - Palpitations

- Head and Neck**
- Headaches
  - Nosebleeds
  - Sore throat

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

- Respiratory**
- Short of breath
  - Cough

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

- Blood clot (DVT/PE)
- Cancer(type) \_\_\_\_\_
- Depression
- Anxiety
- Stroke

- Musculoskeletal**
- Neck Pain
  - Back Pain
  - Joint Pain
  - Muscle Pain

- 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.

- Renal failure
- Sleep apnea
- Osteoporosis

- Gastrointestinal**
- Abdominal pain

- Endocrine**
- Excessive thirst

Other: \_\_\_\_\_

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 \_\_\_\_\_

# NORTHEAST

ORTHOPEDICS AND SPORTS MEDICINE

## 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)

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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