MARSHALL ORTHOPAEDICS / PATIENT HISTORY
MEDICAL HISTORY…*[for yes/no or multiple type choices, circle just one]*

BEST PHONE NUMBER TO REACH YOU: _____ TODAY'S DATE: _____

NAME: _____ HEIGHT : _____ WEIGHT:_____

SS #:_____ DATE OF BIRTH : _____ AGE : _____

REASON FOR VISIT [please give brief description—and ***which side !]*** _____

_____

RESULT OF MOTOR VEHICLE ACCIDENT? yes no IS THIS WORK RELATED ? yes no

OTHER TYPE OF ACCIDENT? yes no DATE OF ACCIDENT : _____

BRIEF DESCRIPTION OF ACCIDENT: _____

_____

ALLERGIC TO ANY MEDICINES? yes no IF SO, WHICH ONES ?:_____

_____

CURRENTLY TAKING ANY MEDICINES? yes no **IF SO, PLEASE LIST THEM ON ATTACHED PAGE**

PAST SURGERY: _____

ANY HEART, LUNG, OR KIDNEY DISORDERS? yes no IF SO, WHAT KIND ? _____

_____

ARE YOU? : right handed left handed SMOKER ? : yes no HOW MANY PACKS A DAY?:_____

DO YOU DRINK ALCOHOL? no rarely socially daily

HAS A ***DOCTOR*** EVER TOLD YOU "DON'T TAKE ARTHRITIS MEDICINES"? yes no

_____

CIRCLE CORRECT ANSWER PLEASE

TAKE BLOOD THINNERS ? : yes no DIABETIC ?: yes no

SUFFER FROM GOUT ? : yes no HIGH BLOOD PRESSURE ?: yes no

TAKING CORTISONE BY MOUTH?: yes no HAD A BLOOD CLOT IN LEGS ?: yes no

HAVE AN ARTIFICIAL HEART VALVE ? yes no HAD A HEART ATTACK OR BYPASS ?: yes no

HAD CANCER ?: yes no HAVE AIDS/HIV ?: yes no HAD A STROKE ?: yes no

HAD EPILEPSY OR SEIZURES ?: yes no EVER HAD HEPATITIS ?: yes no

HAD PROBLEMS WITH ANESTHETICS FOR SURGERY ?: yes no

NAME OF YOUR FAMILY DOCTOR ? _____

FOR WOMEN: ARE YOU PREGNANT OR POSSIBLY PREGNANT? yes no uncertain

Had HYSTERECTOMY? Yes No Had TUBAL LIGATION ? Yes No

WHAT MEDICINES DO YOU TAKE ? PLEASE WRITE THEM HERE, ONE MEDICINE PER LINE, PLEASE

YOUR NAME: ___________________________ TODAY'S DATE:___________________

name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?
name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?
name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?
name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?
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name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?
name of medicine	dosage [“20 mg”, for example]	how often?	from which doctor?

PATIENT REGISTRATION

When registering, please show us proof of insurance, Medicare, or Medicaid. The law requires us to collect any co-pay or deductible amounts due at the time of your visit. If your insurance is not a PPO, then we also collect the patient's share of what your insurance does not cover at the time of your visit. This includes deductibles that are not met. Payment in full is expected at the time of your visit if you have no insurance coverage. We appreciate your understanding and cooperation.

YOUR NAME: _____

YOUR ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

YOUR PHONE: _____ YOUR CELL PHONE: _____

YOUR MARITAL STATUS: _____ YOUR DRIVER'S LICENSE NUMBER [& STATE]_____

STUDENT?: yes no YOUR EMPLOYER'S NAME: _____

YOUR EMPLOYER'S ADDRESS / PHONE: _____

PAYMENT METHOD: ___ CASH ___ CHECK ____MASTERCARD ____VISA

WHO REFERRED YOU TO OUR OFFICE ? _____

YOUR SPOUSE/GUARDIAN / PARENT'S NAME: _____

HOW ARE THEY RELATED TO YOU?: _____

THEIR ADDRESS: _____

THEIR CITY/STATE/ZIP :_____

THEIR DATE OF BIRTH: _____ THEIR SS #: _____ THEIR DRIVER'S. LIC #:_____

THEIR EMPLOYER'S NAME: _____

THEIR EMPLOYER'S ADDRESS/PHONE: _____

RESPONSIBLE PARTY [IF OTHER THAN PATIENT] …if it is your spouse, skip this section and go to emergency contact section

NAME: _____ PHONE : _____ CELL : _____

ADDRESS: _____

CITY/STATE/ZIP: _____

THEIR DATE OF BIRTH: _____ THEIR SS #: _____ THEIR DRIV. LIC # :_____

THEIR EMPLOYER'S NAME: _____

THEIR EMPLOYER'S ADDRESS/PHONE: _____

EMERGENCY CONTACT [someone not living with you]

NAME : _____ PHONE : _____ CELL :_____

ADDRESS : _____

CITY/STATE/ZIP: _____

WAIVER

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me…not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including any deductibles. I understand that the estimated co-pay is neither a guarantee of payment by my insurance company, nor an accurate reflection of my actual co-pay as determined by my insurance company when they process my claim[s]. If my insurance company does not pay on my charges with 30-45 days from receipt of my claim, or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. I understand that balances due over 60 days will be turned over to the Credit Bureau for collection. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment, and will reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance company [ies] that may be responsible for paying benefits to me, and to any attorney who may be representing me due to my condition, and to complete any usual and customary reports and forms to assist in collecting from my insurance company [ies], attorney [s], or other payer [s].

I hereby authorize payment of benefits to be paid directly to:

DOUGLAS E. DUNCAN, M.D.
DOUGLAS A. WALDMAN, M.D.
ARTHUR L. STRAHAN, JR., M.D.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

SIGNATURE OF PATIENT, OR PARENT/GUARDIAN: √_____ DATE : _____

FINANCIAL POLICY

Most insurance companies will only reimburse for services that THEY determine are medically necessary or deemed reasonable and necessary under their individual policies. Should you insurance company determine that a particular service does not meet the criteria under your particular plan:

THE CHARGES WILL THEN BECOME YOUR PAYMENT RESPONSIBILTY

Should you have any questions about your insurance plan coverage and/or policy provisions, and what is or is not covered, we suggest that you check with your insurance company or your plan administrator with your employer.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY, REGARDLESS OF MY INSURANCE STATUS, FOR PROFESSIONAL SERVICES RENDERED BY DOUGLAS E. DUNCAN, M.D. or DOUGLAS A. WALDMAN, M.D. or ARTHUR L. STRAHAN, JR., M.D.

I MUST PAY MY PORTION PRIOR TO THE OFFICE VISIT, WHICH INCLUDES CO-PAYS AND DEDUCTIBLES, AT THE TIME THAT SERVICES ARE RENDERED.

I AM RESPONSIBLE FOR INSURANCE CLAIM DENIALS RESULTING FROM PRE-EXISTING CONDITIONS, UNCOVERED SERVICES, OR OTHER SERVICES DEEMED MY RESPONSIBILITY.

I MUST PAY MY PORTION OF HOSPITAL CHARGES WITHIN 30 DAYS OF RECEIPT OF STATEMENT.

Payment plans for hospital charges must be pre-approved by the office manager. **ALL OTHER PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

SUBSCRIBER'S SIGNATURE: √_____ DATE: _____

PATIENT'S SIGNATURE: √_____ DATE: _____

PATIENT ATTENDANCE POLICY

I understand that I should arrive fifteen minutes before my scheduled appointment to check in. If I arrive more than fifteen minutes after my scheduled appointment time, I may have to reschedule and my visit will be marked as a missed appointment.

Attending follow-up appointments is crucial to providing adequate treatment for medical problems. If I miss three appointments without calling first to cancel or reschedule, then I will have to seek a new physician. If I call to cancel or to reschedule an appointment, then I agree to do so as early as possible.

I understand that the doctors in this clinic are operating surgeons, and as such, their daily schedules can be disrupted at any time for the sake of patients needing immediate care for a condition more serious or emergent than mine. I understand that the doctors will do their best to see me on time, but that circumstances beyond their control often force them to run late or to cancel appointments altogether.

PATIENT: √_____ DATE: _____

GUARANTOR:√_____ DATE : _____

WITNESS: _____ DATE: _____

MARSHALL ORTHOPAEDICS

Consent to the Use and Disclosure of Health Information for Treatment, Payment or HealthCare Operations.

PATIENT: _____

HEALTHCARE PROVIDER: D. Duncan, MD D. Waldman MD A. Strahan, Jr., MD

I understand that as part of my health care, Marshall Orthopaedics [MO] originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatments, and any plan for future care and treatment. This important information may be used and disclosed for my treatment, so that my physician can get paid, and for various uses related to my physician's operations.

I understand that MO's Notice of Information Practices has a more complete description of how my health information may be used and disclosed to carry out these treatments, payments, and health care operations. I have the right to review the notice prior to signing this consent. I understand that MO reserves the right to change those practices described in the Notice of Information Practices and, if it does so, the Notice of Information Practices will also change. A copy of any such change is available to me upon my request.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that MO is not required to agree to the restrictions that I request but if it does agree, it must comply with that agreement.

I have received a copy of MO's Notice of Information Practices, and I hereby consent to MO using and disclosing my health information as described in the Notice of Information Practices, including any changes that this practice may adopt in the future. I understand that I may revoke this consent in writing, except to the extent that MO has already taken action in reliance on this consent.

I request the following restrictions to the use or disclosure of my health care information:

_____ Do not release my HIV test results

_____ OTHER [specify in detail]: _____

_____

PATIENT OR PERSONAL REPRESENTATIVE: √_____

Relationship to patient: _____

WITNESS: _____ DATE SIGNED : _____

Version 10 4/13/10

Douglas E. Duncan, MD
Douglas A. Waldman, MD
Arthur L. Strahan, Jr., MD
Marshall Orthopaedics

POLICY REGARDING COPIES OF X-RAY FILMS

To Our Valued Patients and Friends:

Due to legal and liability reasons, our office cannot release original x-ray films taken here.

We can get the hospital to make copies of your x rays for you. The hospital charges $10 [ten dollars] per film, and it is the patient's responsibility to pay.

If our doctors refer you to another physician, or if you want to see another physician for a second opinion, we ask that you please give us 48 [forty-eight] hours notice [two business days] if you need copies of your x-ray films. This gives us time to take the original films to the hospital to get the copies made.

Thanks very much for understanding.

I have read the above policy and I understand that I will need to give 48 [forty-eight] hours [two business days] notice to Marshall Orthopaedics if I need copies of my x rays made. I also understand that I will have to pay the hospital $10 [ten dollars] per film sheet in advance of having copies made.

_____ _____
Patient / Responsible Party Date

_____ _____
Witness Date

NO SHOW POLICY

If you find that you will have to miss your appointment here, please notify us as soon as possible, during office hours.

If you simply do not keep your appointment, without notifying us, we will add a $25 [twenty five dollar] charge to your account.

This charge will not be paid by your insurance company, and you will have to pay this charge before you can be seen here again.

If you miss three appointments, you are considered a "chronic no-show" and you may be expelled from our practice.

If you consistently call and cancel or re-schedule your appointment, you could also face expulsion.

We understand that sometimes situations are beyond your control, and we will work with you as much as possible. We have had to establish this policy because many patients just don't show up, and cause problems for everyone

Our doctors have a very busy schedule. Patients who simply do not keep their appointments, without notifying us before, cause great hardships for everyone. Not only is our time wasted but, more importantly, medical care for another patient is delayed for no good reason.

Your signature below indicates that you understand and will comply with this policy. Thank you very much.

_____ _____
Signature [patient or responsible party] [date]