

Name:

Chart:

Date:

ADVANCED ORTHOPAEDICS AND REHABILITATION

PATIENT INFORMATION

PT NAME	_____	BIRTHDAY	_____	MARITAL STATUS	_____
ADDRESS	_____	SEX	_____		
CITY-STATE	_____	EMPLOYER	_____		
ZIP	_____	ADDRESS	_____		
HOME PH	_____	CITY-STATE, ZIP	_____		
CELL PH	_____	WORK PH	_____		
SS#	_____	WORK STATUS	_____		
EMERGENCY CONTACT	_____	FAMILY PHYSICIAN	_____		
EMERGENCY PH	_____	PHYSICIAN PH	_____		

GUARANTOR INFORMATION (PARTY RESPONSIBLE FOR PAYMENT OF PERSONAL BALANCE)

GUARANTOR INFORMATION SAME AS ABOVE (IF CHECKED SKIP TO INSURANCE INFORMATION)

GUARANTOR NAME	_____	BIRTHDAY	_____
ADDRESS	_____	SEX	_____
CITY-STATE, ZIP	_____	EMPLOYER	_____
PHONE #	_____	ADDRESS	_____
SS#	_____	PHONE	_____

INSURANCE INFORMATION CHECK BOX IF INSURANCE CARD COPIED (no need to fill out Insurance information)

PRIMARY INS NAME	_____	CITY,STATE,ZIP	_____
ADDRESS	_____	RELATIONSHIP	_____
INSURED'S NAME	_____	INSURED'S SS#	_____
ADDRESS	_____	CITY,STATE,ZIP	_____
PHONE #	_____	EFFECTIVE DATES	_____
ID NUMBER	_____	GROUP NUMBER	_____

SECONDARY INS NAME	_____	CITY,STATE,ZIP	_____
ADDRESS	_____	RELATIONSHIP	_____
INSURED'S NAME	_____	INSURED'S SS#	_____
ADDRESS	_____	CITY,STATE,ZIP	_____
PHONE #	_____	EFFECTIVE DATES	_____
ID NUMBER	_____	GROUP NUMBER	_____

AUTO INSURANCE If injury related to Auto Accident

INSURANCE NAME	_____		
ADDRESS	_____	CITY,STATE,ZIP	_____
INSURED'S NAME	_____		
ADDRESS	_____	CITY,STATE,ZIP	_____
PHONE #	_____	DATE OF ACCIDENT	_____
CLAIM NUMBER	_____	AGENT'S NAME	_____

WORKERS COMPENSATION If injury related to Work Comp

INSURANCE NAME	_____	EMPLOYER	_____
ADDRESS	_____	CITY,STATE,ZIP	_____
PHONE #	_____	DATE OF INJURY	_____
CLAIM NUMBER	_____		

PLEASE SEE FINANCIAL PAYMENT POLICY AND CONSENT FOR COMPLETION

Name: _____

Chart: _____

Date: _____

DOB: _____

Reason for this visit: _____

Height: _____

Occupation/Job duties: _____

Weight: _____

Are you Right or Left hand dominant? Right Left

Age: _____

Please describe to us the reason for your visit: (include onset of symptoms, location, severity, duration)

Date of injury: ____ / ____ / ____

Please describe in your own words how and where the accident occurred:

Do you have any metal in your body? Yes No Where? _____

Do you weld or grind metal? Yes No

Do you have or have you had any of the following? (Please place a checkmark in front of the problem)

- Asthma
- Anemia
- Arthritis Where? _____
- Artificial Joint Which joint(s)? _____

- Blood clot
- Blood diseases
- Blood transfusion
- Cancer: List type _____
- Chemotherapy/Radiation
- Circulatory Problems
- Diabetes
- Do you wear contact lenses? Yes No
- Epilepsy/seizures
- Excessive bleeding
- Glaucoma
- Heart disease/Attack
- Heart murmur
- Heart Valve Replacement
- Hepatitis/jaundice/liver disease
- AIDS/HIV exposure

- Claustrophobia
- High Blood Pressure
- Kidney Stones
- Urinary disease
- Lung clot
- Osteoporosis
- Pacemaker/Defibrillator
- Mental Illness
- Recent weight loss/gain
- Rheumatic Fever
- Sleep Apnea/Do you use a CPAP? Yes No
- Stroke
- Tuberculosis
- Ulcers
- Have you had a tetanus shot in the last ten years? Yes No
- Previous fractures? Yes No

R/L Which bone? _____

Please list your family history of any problems listed above: Father _____ Mother _____

Brother _____ Sister _____ Son _____ Daughter _____

Do you smoke? Yes No How Much? _____ Do you use chewing tobacco? Yes No

Do you consume alcoholic beverages? Yes No If yes, how often? _____

Previous Surgeries: _____

Do you have any disease, problem, or condition not listed? _____

Patient Signature: _____ Date: _____

Name:

Chart:

Date:

ADVANCED ORTHOPAEDICS AND REHABILITATION

FINANCIAL PAYMENT POLICY

Insurance Reimbursement: The medical services rendered are provided directly to you as our patient and, therefore, you are ultimately responsible for payment. If you do not have health insurance coverage, however, we ask that you make payment at the time of service. If you are covered, we will, as a courtesy, submit a claim (for fee reimbursement) to your insurance company for you. Our practice participates with Medicare and many managed care insurance companies. However, due to the increasing number of managed care insurers, it is the sole responsibility of the patient to obtain information from the insurer regarding participation by AOAR in the coverage of services rendered. If you are covered by a company with whom AOAR participates, we will bill them along the guidelines of our contract with them. *However, co-payments, co-insurances, and deductibles are the responsibility of the patient and payment is expected at the time of service.*

THERE MAY BE A \$25.00 SERVICE FEE ON ALL PATIENT BILLINGS FOR CO-PAYS. TO AVOID THE SERVICE FEE, PLEASE MAKE PAYMENT AT THE TIME OF SERVICE PER YOUR CONTRACT.

Payment Arrangements: If you are not covered by health insurance, your policy does not cover services rendered by AOAR or you cannot make full payment due to financial hardship, it will be necessary to set up a payment plan at the time of your visit. If you are in need of special payment arrangements, you must meet with one of our billing staff to make these arrangements prior to leaving the office on the date of your initial visit.

We are here to help: Should you have any questions or comments, please speak with the office receptionist or contact the Practice Manager.

Please Note: All balances over 90 days may be sent to collections

I understand and agree to abide by the financial policy of this office.

Signature _____

Date _____

Print Name _____

Relationship to Patient _____

CONSENT

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other known plans to **Advanced Orthopaedics and Rehabilitation**.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I hereby authorize said assignee to release all information necessary to secure payment.

I understand that charges not covered by my insurance, as well as copays and deductibles, are my responsibility and are due at time of service.

I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE CONSENT FOR AOAR TO FURNISH MEDICAL CARE CONSIDERED NECESSARY IN DIAGNOSING AND TREATING MY CONDITION.

SIGNATURE OF PATIENT OR GUARDIAN _____

DATE _____

ALL COPAYS, COINSURANCES, DEDUCTIBLES, AND BALANCES DUE AT TIME OF SERVICES. THANK YOU

Name:

Chart:

Date:

**Advanced Orthopaedics & Rehabilitation
Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat**

Advanced Orthopaedics & Rehabilitation has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to Contact our Privacy Officer:

Mail: Advanced Orthopaedics & Rehabilitation
100 Trich Drive, Suite 2
Washington, PA 15301-5892

Telephone: (724) 225-8657

Fax: (724) 228-8388

Acknowledgement of Receipt and Consent

I, _____ give my consent to the practitioners of Advanced Orthopaedics & Rehabilitation to perform medical services determined necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Advanced Orthopaedics & Rehabilitation is authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

Medicare Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to Medicare for payment to me.

Name of Patient

Signature of patient (or personal representative)

Date

Personal Representative Name: _____

Relationship/Authority: _____

Good Faith Efforts to Obtain Acknowledgement of Receipt

The above named patient/personal representative was offered the Notice of Privacy Practices.

Describe how notice was provided:

- Offered copy and individual refused to accept delivery
- Offered copy and individual accepted delivery
- Other: _____

Describe efforts to obtain signature on acknowledgement of notice form:

- Patient/personal representative was asked to sign form and refused
- Other: _____

Signature of staff member

Date

Name:

Chart:

Date:

Advanced Orthopaedics & Rehabilitation

Consent to Disclosure of Personal Health Information to Family Members

I, _____, give my permission to the practitioners and staff of Advanced Orthopaedics & rehabilitation to release information regarding my medical care, including my medical condition, test results, appointment dates/times to the following individuals:

Name	Relationship	Telephone Number

Name of Patient

Signature of patient (or personal representative)

Date

Personal Representative Name: _____

Relationship/Authority: _____

Can the staff of this office leave information regarding your care on your answering machine? Yes No Other

Explain: _____

NOTICE OF PRIVACY PRACTICES

Effective July 1, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions regarding this notice, you may contact our privacy officer at:

Advanced Orthopaedics & Rehabilitation
100 Trich Drive, Suite 2
Washington, Pennsylvania 15301-5990
Telephone: (724) 225-8657
Fax: (724) 228-8388

I. Your Protected Health Information

Advanced Orthopaedics & Rehabilitation is required by the federal privacy rule to maintain the privacy of health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. We are required to abide by the terms of the notice currently in effect.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you.

Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

II. Uses and Disclosures of Your Protected Health Information

A. Treatment, payment and health care operations

This section describes how we may use and disclose your protected health information for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations will be listed.

Treatment – We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- During an office visit, practice physicians and other staff involved in your care may review your medical record and share and discuss your medical information with each other.
- We may share and discuss your medical information with an outside physician to whom we have referred you for care.
- We may share and discuss your medical information with an outside physician with whom we are consulting regarding you.
- We may share and discuss your medical information with an outside laboratory, radiology center, or other health care facility where we have referred you for testing.

- We may share and discuss your medical information with an outside home health agency, durable medical equipment agency or other health care provider to whom we have referred you for health care services and products.
- We may share and discuss your medical information with a hospital or other health care facility where we are admitting or treating you.
- We may share and discuss your medical information with another health care provider who seeks this information for the purpose of treating you.
- We may use a patient sign-in sheet in the waiting area which is accessible to all patients.
- We may page patients in the waiting area when it is time for them to go to an examining room.
- We may contact you to provide appointment reminders.

Payment – We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, from your health insurer. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.
- Submission of a claim form to your health insurer.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.
- Sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you.
- Mailing you bills in envelopes with our practice name and return address.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.
- Allowing your health insurer access to your medical record for a medical necessity or quality review audit.
- Providing consumer reporting agencies with credit information (your name, address, date of birth, social security number, payment history, account number and our name and address).
- Providing information to a collection agency or our attorney for purposes of securing payment of a delinquent account.
- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

Health Care Operations – We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities.
- Population based activities related to improving health or reducing health care costs.
- Reviewing the competence, qualifications, or performance of health care professionals.

- Conducting training programs for medical and other students.
- Accreditation, certification, licensing, and credentialing activities.
- Health care fraud and abuse detection and compliance programs.
- Conducting other medical review, legal services and auditing functions.
- Business planning and development activities, such as conducting cost management and planning related analyses.
- Sharing information regarding patients with entities that are interested in purchasing our practice and turning over patient records to entities that have purchased our practice.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.

B. Uses and Disclosures for Other Purposes

We may use and disclose your protected health information for other purposes. This section generally describes those purposes by category. Each category includes one or more examples. Not every use or disclosure in this category will be listed. (Some examples fall into more than one category, not just the category under which they are listed.)

Individuals involved in care or payment for care – We may disclose your protected health information to someone involved in your care or payment for your care, such as a spouse, a family member, or close friend. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your post-operative care.

Notification purposes – We may use and disclose your protected health information to notify, or to assist in the notification of, a family member, personal representative, or another person responsible for your care, regarding your location, general condition, or death. For example, if you are hospitalized, we may notify a family member of your general condition and where you were admitted. In addition, we may disclose your protected health information to a disaster relief entity, such as the Red Cross, so that it can notify a family member, a personal representative, or another person involved in your care regarding your location, general condition, or death.

Required by law – We may use and disclose protected health information when required by federal, state, or local law. For example, we may disclose protected health information to comply with mandatory reporting requirements involving births and deaths, child abuse, disease prevention and control, vaccine-related injuries, medical device-related deaths and serious injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments and blood alcohol testing.

Other public health activities – We may use and disclose protected health information for public health activities, including:

- Public health reporting, for example, communicable disease reports.
- Child abuse and neglect reports.
- FDA-related reports and disclosures, for example, adverse event reports.
- Public health warnings to third parties at risk of a communicable disease or condition.
- OSHA requirements for workplace surveillance and injury reports.

Victims of abuse, neglect or domestic violence – We may use and disclose protected health information for purposes of reporting abuse, neglect or domestic violence in addition to child abuse, for example, reports of elder abuse to the Department of Aging or abuse of a nursing home patient to the Department of Public Welfare.

Health oversight activities – We may use and disclose protected health information for purposes of health oversight activities authorized by law. These activities could include audits, inspections, investigations, licensure actions, and legal proceedings. For example, we may comply with a Drug Enforcement Agency inspection.

Judicial and administrative proceedings – We may use and disclose protected health information in judicial and administrative proceedings in response to a court order or subpoena, discovery request or other lawful process. For example, we may comply with a court order to testify in a case at which your medical condition is at issue.

Law enforcement purposes – We may use and disclose protected health information for certain law enforcement purposes including to:

- Comply with legal process, for example, a search warrant.
- Comply with a legal requirement, for example, mandatory reporting of gun shot wounds.
- Respond to a request for information for identification/location purposes.
- Respond to a request for information about a crime victim.
- Report a death suspected to have resulted from criminal activity.
- Provide information regarding a crime on the premises.
- Report a crime in an emergency.

Coroners and medical examiners – We may use and disclose protected health information for purposes of providing information to a coroner or medical examiner for the purpose of identifying a deceased patient, determining a cause of death, or facilitating their performance of other duties required by law.

Funeral directors – We may use and disclose protected health information for purposes of providing information to funeral directors as necessary to carry out their duties.

Organ and tissue donation – We may use protected health information and disclose protected health information to entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for purposes of facilitating organ, eye and tissue donation and transplantation.

Threat to public safety – We may use and disclose protected health information for purposes involving a threat to public safety, including protection of a third party from harm and identification and apprehension of a criminal. For example, in certain circumstances, we are required by law to disclose information to protect someone from imminent serious harm.

Specialized government functions – We may use and disclose protected health information for purposes involving specialized government functions including:

- Military and veterans activities.
- National security and intelligence.
- Protective services for the President and others.
- Medical suitability determinations for the Department of State.
- Correctional institutions and other law enforcement custodial situations.

Workers' compensation and similar programs – We may use and disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. For example, this would include submitting a claim for payment to your employer's workers' compensation carrier if we treat you for a work injury.

Business associates – Certain functions of the practice are performed by a business associate such as a billing company, an accountant firm, or a law firm. We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf. For example, we may share with our billing company information regarding your care and payment for your care so that the company can file health insurance claims and bill you or another responsible party.

Creation of de-identified information – We may use protected health information about you in the process of de-identifying the information. For example, we may use your protected health information in the process of removing those aspects which could identify you so that the information can be disclosed to a researcher without your authorization.

Incidental disclosures – We may disclose protected health information as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.

C. Uses and Disclosures with authorization

For all other purposes which do not fall under a category listed under sections II.A and II.B, we will obtain your written authorization to use or disclose your protected health information. Your authorization can be revoked at any time except to the extent that we have relied on the authorization.

III. Patient Privacy Rights

A. Further restriction on use or disclosure.

You have a right to request that we further restrict use and disclosure of your protected health information:

- To carry out treatment, payment, or health care operations
- To someone who is involved in their care or the payment for your care, or
- For notification purposes.

We are not required to agree to a request for a further restriction. We will provide a response to your request within a specified time frame.

To request a further restriction, you must submit a written request to our privacy officer. The request must tell us:

- What information you want restricted
- How you want the information restricted; and
- To whom you want the restriction to apply.

We will provide a response to your request within a specified time frame.

B. Confidential communication

You have a right to request that we communicate your protected health information to you by a certain means or at a certain location. For example, you might request that we only contact you by mail or at work. We are not required to agree to requests for confidential communications that are unreasonable.

To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled. We will provide a response to your request within a specified time frame.

C. Accounting of disclosures

You have a right to obtain, upon request, an "accounting" of certain disclosures of your protected health information by us (or a business associate for us). This right is limited to disclosures within six years of the request and other limitations. Also in limited circumstances we may charge you for providing the accounting. To request an accounting, you must submit a written request to our privacy officer. The request should designate the applicable time period. We will provide a response to your request within a specified time frame.

D. Inspection and copying

You have a right to inspect and obtain a copy of your protected health information that we maintain in a designated record set. This right is subject to limitations, and we may impose a charge for the labor and supplies involved in providing copies.

To exercise your right of access, you must submit a written request to our privacy officer. The request must:

- Describe the health information to which access is requested,
- State how you want to access the information, such as inspection, pick-up of copy, mailing of copy, etc.
- Include the mailing address, if applicable.

We will provide a response to your request within a specified time frame.

E. Right to amendment

You have a right to request that we amend protected health information that we maintain about you in a designated records set if the information is incorrect or incomplete. This right is subject to limitations. To request an amendment, you must submit a written request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change. We will provide a response to your request within a specified time frame.

E. Paper copy of privacy notice

You have a right to receive, upon request, a paper copy of our Notice of Privacy Practices. To obtain a paper copy, contact our privacy officer.

IV. Changes to this Notice

We reserve the right to change this notice at any time. We further reserve the right to make any change effective for all protected health information that we maintain at the time of the change – including information that we created or received prior to the effective date of the change.

We will post a copy of our current notice in the waiting room for the practice. At any time, patients may review the current notice by contacting our privacy officer.

V. Complaints

If you believe that we have violated your privacy rights, you may submit a complaint to the practice or the Secretary of Health and Human Services. To file a complaint with the practice, submit the complaint in writing to our privacy officer. We will not retaliate against you for filing a complaint.

VI. Legal Effect of This Notice

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.

(This notice was created based on a document published by and used with express permission of the Pennsylvania Medical Society, 9/10/02))



PATIENT'S NAME: _____

DOB: _____

PHARMACY INFORMATION

NAME: _____

ADDRESS: _____

PHONE: _____

*If you do not know your pharmacy's phone number, please put down at least the street and city.