

The Central Orthopedic Group, LLP PLV / RVC

DATE _____

Patient Last name _____ First _____ DOB _____ Age _____

Parent or Guardian (if under 18) _____ Contact Phone # _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work # _____ Cell # _____

S.S. # _____ Male _____ Female _____ Employer _____ Email: _____

Referring Physician _____ Address _____

Telephone # _____ Fax # _____

Primary care physician _____

Address _____ Telephone # _____ Fax # _____

Pharmacy Name _____ **Telephone #** _____ **Address** _____

BODY PART _____ **RIGHT / LEFT (CIRCLE)**

Date of Injury _____ **Duration of Problem** _____

Seen in Emergency room? YES OR NO (CIRCLE) **Date** _____ **Name of Facility** _____

X-Rays Taken ? YES OR NO **Date** _____ **Facility** _____

MRI/ CT SCAN Taken? YES OR NO **Date** _____ **Facility** _____

IS THIS WORK OR CAR RELATED? YES OR NO SIGN _____ **DATE** _____

PRIVATE INSURANCE INFORMATION:

Name of Insurance Company _____ Policy # _____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company _____ Policy # _____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to : The Central Orthopedic Group, LLP. I understand that I am financially responsible for treatment rendered.

Signature of Patient or Authorized Representative: _____

Date _____

GUARANTEE AGREEMENT

INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES

In the event that I fail to provide the Central Orthopedic Group, LLP with valid No Fault information or if it is determined by the No fault Carrier that the condition is not a result of the accident as state above, I agree to pay for all medical services rendered to me by the Central Orthopedic Group, LLP.

Signature of Patient or Authorized Representative: _____

Date _____

PATIENT HISTORY FORM

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

TODAY'S DATE _____ / _____ / _____ DATE OF LAST PHYSICAL EXAM _____ / _____ / _____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ / _____ / _____ AGE _____

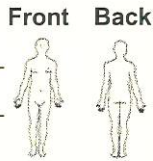
CHIEF COMPLAINT:
WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL) _____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

WHERE IS YOUR PAIN OR PROBLEM?

Left _____ Right _____



If you are in pain, on a Scale of 1-10, with 10 being the most severe, circle the number that best describes your pain.

1 2 3 4 5 6 7 8 9 10

WHEN DID THIS PROBLEM START? _____

DOES ANYTHING HELP OR MAKE THE PROBLEM WORSE? _____

HOW LONG DOES THE PROBLEM LAST?
 30 minutes 1 hour It is always there

OTHER _____

IS ANYTHING ELSE OCCURRING AT THE SAME TIME?

Check Yes or No

Yes No If yes, please explain.

Nausea Rash Headaches

Other _____

IS YOUR PAIN Dull Sharp

Always there Other _____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS?

Yes No If yes, please explain:

Physician Use Only:
(Comments/Notes)

MEDICAL HISTORY

Do you take any of the below Daily ? :

Daily Aspirin Yes No

Blood Thinners Yes No

Oral Contraceptives Yes No

CURRENT MEDICATIONS None

Check One:

Are you Right or Left handed?

Possibility of being pregnant? Yes No

MEDICAL PROBLEMS None
(ex: diabetes, high blood pressure, heart disease, cancer)

PREVIOUS SURGERIES None
Date

PLEASE LIST:

DRUG ALLERGIES None

LATEX ALLERGY? Yes No

TAPE / ADHESIVE Yes No

FOOD/ENVIRONMENTAL ALLERGIES
 None

OVER →

FAMILY AND SOCIAL HISTORY

LIST ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY. None

(example: diabetes, tuberculosis, heart disease, cancer)

RELATIONSHIP

Check One:

Yes No

Do you smoke? Yes No
(If yes, how much) _____

Do you drink? Yes No
(If yes, how much) _____

Do you live alone? Yes No
Occupation _____

REVIEW OF SYSTEMS

Do you currently have any of these symptoms? Check YES or NO. Please explain any YES answers in the space provided

CARDIOVASCULAR: Yes No

Chest Pain Yes No
 Varicose Veins Yes No
 High Blood Pressure Yes No
 Other _____

CONSTITUTIONAL: Yes No

Fever Yes No
 Chills Yes No
 Headache Yes No
 Other _____

EYES : Yes No

Blurred Vision Yes No
 Double Vision Yes No
 Eye Pain Yes No
 Other _____

GASTROINTESTINAL: Yes No

Abdominal Pain Yes No
 History of Ulcers Yes No
 Indigestion/Heartburn Yes No
 Nausea/Vomiting Yes No
 Other _____

GENITOURINARY: Yes No

Urine Retention Yes No
 Painful Urination Yes No
 Urinary Frequency Yes No
 Other _____

**HEMATOLOGIC/
LYMPHATIC:** Yes No

Swollen Glands Yes No
 Blood Clotting Yes No
 Problem Yes No
 Other _____

INTEGUMENTARY: Yes No

Skin Rash Yes No
 Boils Yes No
 Persistent Itch Yes No
 Other _____

MUSCULOSKELETAL: Yes No

Joint Pain Yes No
 Neck Pain Yes No
 Back Pain Yes No
 Other _____

NEUROLOGICAL: Yes No

Tremors Yes No
 Dizzy Spells Yes No
 Numbness/Tingling Yes No
 Other _____

PSYCHOLOGICAL:

History of Depression YES NO
 Sleep Disturbances YES NO
 Anxiety Disorder YES NO
 Other _____

RESPIRATORY: Yes No

Wheezing Yes No
 Frequent Cough Yes No
 Shortness of Breath Yes No
 Other _____

PHYSICIAN USE ONLY: (Comments/Notes)

X _____
Signature of Patient/Authorized Individual

_____/_____/_____
Date

VITAL SIGNS:

(To be completed by Medical Assistant)

Temp: _____

Pulse: _____

Weight: _____

Initial: _____

Physician _____ / _____ / _____
 Signature

DATE: _____ PATIENT NAME: _____ ACCOUNT # _____

CONSENT INFORMATION

CONSENT TO TREAT:

The information I have given to the Central Orthopedic Group is complete and true to the best of my knowledge. I authorize the doctors/PAs and staff of The Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary. The Central Orthopedic Group physicians/PAs and staff have implied no guarantee of cure. **initial here** _____

CONSENT TO TREAT A MINOR CHILD:

The information I have given to the Central Orthopedic Group, pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors/PAs and staff of the Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary to my child/ward in my legal custody, (if no any legal attachments) I have a signed letter giving permission to sign all documents as acting guardian. **Parent/Guardian initials** _____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster and/or attorney involved in this case.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

**Central Orthopedic Group, LLP
651 Old Country Road
Plainview, NY 11803**

Patient/Guardian Signature _____ **Date** _____

MEDICARE PATIENTS:

We will submit to Medicare for the Medicare allowed amount. The patient is responsible for the deductible and the 20% co-insurance, which can be billed to the secondary insurance. It is your responsibility to give the Central Orthopedic Group your secondary insurance so that we can bill your balance for you. Not all secondary's cover this deductible.

I request that payment of authorized Medicare benefits be made on my behalf to the Central Orthopedic Group for services furnished to me by the provider. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services. I understand the terms of the Central Orthopedic Group as stated above. _____

Initial here

OUT OF NETWORK INSURANCE:

If you have an insurance plan that has Out Of Network Policy, you may agree to see a Doctor who does not participate with your carrier. Please sign below stating that you agree to pay your Doctor the amount that is paid to you by your insurance and any out of network portion that is your responsibility _____

Initial here

SCHOOL, SPORTS, CAMPS OR TOWN ACTIVITIES:

Patients who have been involved in a sports related accident through schools, camps, or town activities. We do not accept third party billing! You are responsible for all charges according to your own insurance policy agreement. Once all fees are paid to us by your insurance carrier and by you, we will then issue you a paid receipt for you to forward to the third-party payor involved. They will reimburse you directly.

Initial here

PERSONAL INJURY PATIENTS:

You are responsible for all services directly to The Central Orthopedic Group, LLP. Once all services have been paid in full, we will then issue you a paid receipt for you to forward to your outside party involved

Initial here

WORKERS' COMPENSATION INJURY:

You are responsible for providing the Central Orthopedic Group, LLP with your Workers' Compensation billing information. If this is not received at the initial visit, we will collect a \$250 deposit prior to the service. This \$250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified.

Initial here

NO FAULT INJURIES:

You are responsible for providing the Central Orthopedic Group, LLP. Your No Fault billing information at the time of your initial visit. If this is not received at the initial visit, we will collect a \$250 deposit prior to the service. This \$250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified.

Initial here

IN NETWORK INSURANCE:

PRIVATE INNENETWORK INSURANCE WILL BE COLLECTED AT THE TIME OF YOUR INITIAL VISIT ALONG WITH A PHOTO COPY OF YOUR VALID IDENTIFICATION CARD. You will be responsible to know your insurance. If a referral is needed it is your responsibility to GET ONE or your visit will be canceled. If you have a coinsurance, deductible and or copay you are responsible to pay this at the time of your visit. KNOW YOUR INSURANCE EACH SERVICE YOU ARE RECEIVING MAY REQUIRE A SEPARATE COINSURANCE, COPAY OR DEDUCTIBLE. PLEASE DO NOT ASSUME PAYING YOUR COPAY IS YOUR ONLY RESPONSIBILITY.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND AUTHORIZE TO RELEASE:

I acknowledge that upon my request I will be provided with a copy of Central Orthopedic Group, LLP, HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information. _____

I _____, agree that the initialed information above it true and correct to the best of my
Print responsible party name

knowledge. I hereby permit my insurance company or the company that is processing my claims to pay The Central Orthopedic Group, LLP directly.

Patient name: _____

Patient/Guardian Signature _____ Print _____ Date _____