

PATIENT INFORMATION: Please use full legal name ***Avoid Nicknames**

() Jr. () Sr. () Other _____ () Dr. () Mr. () Mrs. () Ms.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City/State/Zip _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: () Single () Married () Divorced () Widowed

Social Security#: _____ Driver's License#: _____ Home Phone#: (_____) - _____

Employer Name and Address: _____ Cell Phone#: (_____) - _____

Occupation: _____ Work Phone#: (_____) - _____

Emergency Contact Name: _____ Relationship to Patient: _____ Emergency #: (_____) - _____

Email: _____ May we send you a survey via EMAIL regarding your visit? Yes No

How did you hear about us/Referred by: _____

GUARANTOR INFORMATION: Person responsible for bill or insurance subscriber

Relationship of Guarantor to Patient: _____ SELF (Please skip to the next section) _____ Spouse _____ Parent _____ Other

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Home Phone#: (_____) _____ Cell Phone#: (_____) _____ Work Phone: (_____) _____

Social Security#: _____ Age: _____ Sex: () Female () Male

Employer Name/Address: _____

INSURANCE INFORMATION: Please present your insurance card/documentation and identification for photocopying

PRIMARY INSURANCE:

Insurance Plan Name: _____ Insured's Name: _____ DOB: _____

Insured's SS# _____ Policy ID# _____ Group# _____

Claims Mailing Address: _____

Claims Phone #: (_____) - _____ Effective Date: _____ Expiration Date: _____

SECONDARY INSURANCE:

Insurance Plan Name: _____ Insured's Name: _____ DOB: _____

Insured's SS#: _____ Policy ID# _____ Group# _____

Claims Mailing Address: _____

Claims Phone#: (_____) - _____ Effective Date: _____ Expiration Date: _____

I agree that the information supplied on this form is current and accurate to the best of my knowledge. I hereby assign to ELITE ORTHOPAEDICS, any insurance or other third-party benefits available for healthcare services provided to me. I understand that ELITE ORTHOPAEDICS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to ELITE ORTHOPAEDICS, I agree to forward any health insurance and other third-party payments to ELITE ORTHOPAEDICS that I received for services rendered to me immediately upon receipt. I authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. This agreement/authorization applies to all insurances, including Medicare. *** I acknowledge that I have received a copy of the HIPPA Privacy Policies and understand that if I have any questions or complaints, I should contact the Privacy Official.

Patient/Responsible Party Signature: _____ Date: _____

Elite Orthopaedics

Michael E. Muncy, D.O.
Stephanie R. Stephens, M.D.

Welcome to our Practice! Elite Orthopaedics believes that in the interest of good health care practices, it is best to establish practice guidelines/policies between our patients and ourselves in order to avoid any misunderstandings. Our primary goal and responsibility is to provide quality healthcare and a positive experience. **Please read through and initial each line;** by initialing and signing you are acknowledging that you understand our guidelines/policies.

Copays, Co-insurance, Deductibles

_____ We expect that all co-pays, co-insurance and deductibles are paid in full at each visit and prior to surgery. We accept cash, check, debit cards and credit cards.

Billing and Insurance Information

_____ As a courtesy, we do submit insurance claims for our patients. You must bring your insurance card with you to every visit and make us aware of any changes in coverage. **Lack of notification in change of coverage, or presentation of incorrect coverage, will result in patient responsibility for all charges.** We also require a driver's license to confirm identity.

_____ Please remember insurance coverage is a contract between the patient and the insurance company. Elite Orthopaedics will look to the patient for payment in full if insurance does not cover the services provided. **In the event your insurance carrier has not paid within 60 days you are responsible for the balance due and we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor.** Failure to promptly resolve this balance may result in third party collection and/or legal procedures be taken. We participate with most insurance plans; however, it is the patient's responsibility to ensure proper authorization and physician participation before making an appointment.

_____ Please keep a close watch for the carrier Explanation of Benefits (EOB) to be sent to you from the carrier reflecting claim payment and amount you may possibly owe provider. **As a courtesy, monthly statements are mailed to the patient's address on file. For patient balances not paid in full within 90 days, we reserve the right to formally transfer all associated liability for the claim to third party collection and/or legal action.**

_____ **We do not file any insurance with your Automobile Insurance Company, or any other third-party (attorney, business insurance company, employer, separated spouses, etc.) for the purpose of obtaining payment.** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e. receipt, patient ledger, medical reports). We do not accept letters of guarantee or other promises to pay when cases settle.

Physician Referrals

_____ It is the patient's responsibility to obtain referrals from your primary care physician and ensure we are in receipt of them. **If the referral is NOT obtained before the visit, the patient is liable for payment in full on the date of service.**

Wait Time

_____ At Elite Orthopaedics we understand your time is valuable and that every patient, and their condition, is unique with different needs which may require more time than planned. Therefore, we will make every effort to provide you with the highest quality care and to minimize your waiting time. **As this is a surgical practice, there may be times that a surgery may arise or take longer than expected which may cause a delay or rescheduling of your appointment. Every effort will be made to accommodate for this, and in the event of a delay or emergency we will do our best to notify you as soon as possible.**

Late Arrival

_____ We make every effort to stay on schedule, therefore it is the policy of Elite Orthopaedics that if you're **15 minutes LATE arriving to your scheduled appointment you may be rescheduled.** If you're going to be late, please call the office to reschedule.

Telephone Calls and Medical Questions

_____ Each physician has a dedicated clinical team to assist in providing your care. When you call with a routine medical question or request, the front office staff will connect you with the clinical team. **Except in emergencies, our physicians and/or clinical**

teams do NOT accept calls while they are in clinic with patients. If you call when your team is in clinic, the front office staff will gladly take a message or forward you to the team's voicemail. The team will respond to your call either between patients (time permitted), by the end of the day, or within 24 hours.

Prescription Refill Guidelines

Think ahead! Our office requires **48-hour notice for prescription refills, no exceptions.**

- Medications will be refilled between **8 AM and 4 PM Monday-Friday**. No refills on the weekends or holidays. The "on-call" physician will NOT refill medications.
 - Safety of your prescription is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medications and keep them away from children.
 - Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
 - Be aware of the effect of other medications you may be taking. Ask your doctor or pharmacist whether you can take them along with pain medication.
 - Do not drink alcohol while taking pain medication. Obey warnings regarding sedation of certain medicines.
 - Follow the prescribed dose of the medication. Do not give your medications to other people and do not take medication from others.
-

Form Completion

Effective July 1, 2010, there is a **\$20 charge per occurrence** for the completion of the following forms:

- Disability
- FMLA
- AFLAC
- Supplemental Insurance
- Dictated Work Excuse
- Medical Hardships

Payment is due when forms are presented. Forms will not be processed without payment. **Please allow 5 to 7 working days for the completion of forms.**

Patient/Guardian Signature: _____ **Date:** _____

MEDICAL QUESTIONNAIRE

Orthopaedic Surgery

Patient Name: _____

BP _____ / _____	Pulse _____
Temp. _____	Ht _____ Wt _____

Age: _____ F M Dominant Hand: R L Did you bring x-rays? Y N

Who requested that you visit this office? _____

*What is the main reason for your this visit: Pain Numbness Weakness Swelling Stiffness
 Other _____

(C.C.)

*What body part is involved? Please mark in the table below.

Neck and <input type="checkbox"/> radiates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	Hand	<input type="checkbox"/> R <input type="checkbox"/> L	Pelvis	<input type="checkbox"/> R <input type="checkbox"/> L	Knee	<input type="checkbox"/> R <input type="checkbox"/> L	Foot	<input type="checkbox"/> R <input type="checkbox"/> L
Back and <input type="checkbox"/> radiates to	<input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	Arm	<input type="checkbox"/> R <input type="checkbox"/> L	Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	Finger	<input type="checkbox"/> R <input type="checkbox"/> L	Hip	<input type="checkbox"/> R <input type="checkbox"/> L	Ankle	<input type="checkbox"/> R <input type="checkbox"/> L	Toe	<input type="checkbox"/> R <input type="checkbox"/> L

*How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years.

Have you had a problem like this before? Yes No

(Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was: Gradual or Sudden

Why do you think it started? _____

INJURY (Sport Accident - NOT Auto or Work)

Date _____ Where and how did it happen? _____

What sport? _____

INJURY AT WORK Date _____

From a lift twist fall bend pull reach ?

WORK-RELATED - (BUT NO INJURY)

Date _____ How did your job cause this problem? _____

AUTO ACCIDENT Date _____

ANSWER:

COMMENTS

On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

(Severity)

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

(Quality)

The pain is Constant Comes and goes. Does your pain wake you from sleep? Y N

(Timing)

Do you have? Swelling Bruise Numbness Tingling Weakness Loss of control of bowel or bladder

Since my problem started, it is: Getting better Getting worse Unchanged

(Context)

What makes your symptoms worse? Standing Walking Lifting Exercise Twisting

Lying in bed Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

(Modify)

What takes your symptoms better? Rest Elevation Ice Heat Other _____

(Modify)

What medications are you taking now (or previously) for this problem? _____

(Modify)

Have you had any of these treatments? Injection Brace Physical Therapy Cane/Crutches

(Modify)

What test/scans have you had for this problem? X-rays MRI CT scan Bone scan Nerve test (EMG)

Current work status? Regular Light Duty (how long? _____) Not working due to this problem

Disabled Retired Student Unemployed

When is the last date you worked your regular job? _____

ALLERGY Do you have **ALLERGIES** to any medications? Yes No **If yes, list below:**

MEDICATION	REACTION	MEDICATION	REACTION

REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE/HAVE HAD:

NONE

Describe

M/S	Osteo/Rheumatoid Arthritis	Gout	Back pain	<input type="checkbox"/>	_____
GI	Heartburn	Ulcers	Nausea Vomiting	Blood in stool	<input type="checkbox"/>
ENDO	Frequent thirst	Frequent urination	Always hot/cold	<input type="checkbox"/>	_____
CONST	Weight loss	Frequent fever	Loss of appetite	<input type="checkbox"/>	_____
EYE	Blurred vision	Double vision	Vision loss	<input type="checkbox"/>	_____
ENT	Hearing loss	Hoarseness	Trouble swallowing	<input type="checkbox"/>	_____
C-VASC	Chest pain	Palpitations		<input type="checkbox"/>	_____
RESP	Chronic cough	Shortness of breath	Sleep apnea	<input type="checkbox"/>	_____
GU	Painful urination	Blood in urine	Kidney problems	<input type="checkbox"/>	_____
SKIN	Frequent rashes	Skin ulcers	Psoriasis	<input type="checkbox"/>	_____
NEURO	Headaches	Dizziness	Seizures	<input type="checkbox"/>	_____
PSYCH	Drug/alcohol problem	Depression	Insomnia	<input type="checkbox"/>	_____
HEME	Easy bleeding	HIV/AIDS	Hemophilia	<input type="checkbox"/>	_____

***PAST MEDICAL HISTORY:**

WHAT MEDICATIONS DO YOU TAKE? None

Please list below with dosage.

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

HAVE YOU EVER HAD/DO YOU HAVE? Circle any conditions below: I do not have any of the conditions listed below.

- | | | | |
|-----------------|------------------|----------------------------|--------------------------|
| Asthma | Stroke | Heart attack (when?) _____ | High cholesterol |
| Ulcers | Kidney failure | High blood pressure | Cancer (location?) _____ |
| Hepatitis | Heart failure | Liver disease | Notes/Other: |
| Seizures | Emphysema/COPD | Blood clots (DVT) or P.E. | _____ |
| Thyroid problem | Bipolar disorder | Diabetes | _____ |

***PAST SURGICAL HISTORY:**

What operations have you had (for any reason)? When? None _____

***FAMILY HISTORY:** Have any direct relatives had any of the following disorders? If so, which relative?

- Heart Disease _____ Lung cancer _____ Breast cancer _____ Diabetes _____
- Rheumatoid arthritis _____ Kidney disease _____ Other _____

***SOCIAL HISTORY:**

Do you use tobacco? Y N Packs/day _____ Alcohol use? None Social Daily Frequently

Illegal Drug use? Y N What type? _____

Occupation: _____ Student (What grade?)

PLEASE SIGN: The information on these 2 forms is accurate to the best of my knowledge. _____

Notification

Elite Orthopaedics would like to contact you for various reasons, including **Protected Health Information (PHI)** related to Appointments, Appointment Reminders, Test Results, X-Ray Results, Medications, Medical Status, and Surgery Scheduling if applicable. Please check the following:

- Yes** **No** PHI information left at the Telephone Number(s) and/or E-Mail address I provided.
- Yes** **No** PHI Mailed to address I provided.

Do you give our office permission to discuss your Protected Health Information with other parties and for these parties to be present during the examination if you so choose?

- Yes** **No** If yes, please provide their names:

Spouse (List Name): _____

Parent (List Name): _____

Parent (List Name): _____

OTHER (List Name): _____

OTHER (List Name): _____

I understand that as a part of my continuing healthcare, my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnosis and treatment plans, to be used on a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that this document is a part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I must **notify the physician in writing of these changes.**

Print Name

Signature

Date