SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

Patient Registration Information

Name: _____ Date of Birth: _____ Age: _____ Sex: _____
Social Security # _____ Marital Status: Single Married Widowed Divorced
Address: _____(Apt # ___) City: _____ State: _____ Zip: _____
Home Phone #: _____Cell Phone # _____ Work Phone #: _____
Primary Care Physician: _____ Address: _____ Phone: _____
Employer: _____ Occupation: _____
Employer Address: _____

Spouse or Parent's Name: _____
Person to contact in case of an emergency: _____ Phone: _____

Pharmacy Name/Address/Phone Number:_____

BODY PARTS / INJURY / COMPLAINTS: _____

Date of Injury: _____
Describe How and Where Injury Occurred: _____
Are you out of work due to this injury? Yes No Date Returned to Work: _____

ARE INJURIES RELATED TO:
An Auto Accident? YES NO A Work Related Injury? YES NO

RESPONSIBLE PARTY / POLICY HOLDER INSURANCE INFORMATION:

Responsible Party/Policy Holder: _____
Relationship to Patient: self spouse parent
Date of Birth: _____ Social Security #: _____
Address: _____(Apt # _____) City: _____ State: _____ Zip: _____
Employer: _____ Work Phone #: _____

INSURANCE INFORMATION:

PRIMARY Insurance Company: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
PATIENT Insurance ID #: _____ Group #: _____

SECONDARY Insurance Company: (for Medicare Recipients Only)_____
PATIENT Insurance ID #: _____ Group #: _____
Responsible Party/Policy Holder:_____
Relationship to Patient: self spouse parent
Policy holder DOB:_____ and Social Security #:_____

Assignment of Benefits - Financial Agreement

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child, during the period of such care, to third party payers and/or health care practitioners.
I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me.
In the event that the provider's charges are outstanding, or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the provider's charges.
I have reviewed the above information and it is true and accurate.

_____ _____
Signature of patient, or parent (if minor) Date

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MEDICAL HISTORY FORM

NAME: _____ DATE: _____

Chief Complaint: _____ Date of Injury: _____

History of present illness:

Location of pain/problem: _____

How severe is pain/problem (on a scale of 1 – 10) (10 being the worst) _____

Does this pain/problem occur at a specific time? _____

What other signs or symptoms are you having? _____

How long have you had this pain/problem? _____

Where were you at the onset of this pain/problem? _____

What makes the pain/problem better or worse? _____

Have you had previous episodes? _____

How did it start? _____

Allergies to food: _____ □ none

Allergies to medicine: _____ □ none

What medications do you take either prescription or non-prescription:

_____

Previous Surgeries (what kind, where, when?) _____

_____

Previous Hospitalizations (for what, where, when?) _____

_____

Previous Fractures: (of what, when?) _____

Past Medical History:

(Check YES or NO for all)

Diabetes	□ yes	□ no
High Blood Pressure	□ yes	□ no
Cancer	□ yes	□ no
(what kind) _____		
Stroke	□ yes	□ no
Heart Trouble	□ yes	□ no
Arthritis	□ yes	□ no
Convulsions/Seizures	□yes	□ no
Bleeding Tendency	□ yes	□ no
Acute Infection	□ yes	□ no
Venereal Disease	□ yes	□ no
Hereditary Defects	□ yes	□ no
Blood Clots	□ yes	□ no
Gout	□ yes	□ no

What other medical problems to you have? _____

_____

Review of Systems: (check if DENIED / CIRCLE items)

	DENIES	**SYMPTOMS**
Neurological		Headache fainting dizziness seizure numbness tingling weakness
Eyes / Ears / Nose		Vision change double vision pain hearing change ringing in ears smelling change nose bleeds congestion
Throat		Pain difficulty swallowing painful swallowing
Respiratory		Cough wheezing pain asthma short of breath blood in sputum
Cardiovascular		Chest pain palpitations irregular heartbeat swelling skin/color/tem change murmur
GI		Nausea vomiting blood in stool constipation diarrhea bleeding appetite change weight change pain
GU		Frequency hesitancy urgency blood in urine incontinence discharge pain painful urination
Musculoskeletal		Swelling range of motion change pain
Skin		Rash skin change pain itchiness
Psych / Subst Abuse		History of treatment: _____Out-Patient In-Patient Over _____months_____years

Patient Social History:

What kind of work do you do? _____

Are you: □ right handed □ left handed

Marital Status □ single □ married □ separated □ divorced □ widowed

Use of alcohol □ never □ rarely □ moderate □ daily □ recovering alcoholic

Use of tobacco □ never □ previously, but quit □ current pack/day

Use of drugs □ never □ type/frequency

Excessive exposure at home or work to □ fumes □ dust □ solvents □ noise

Family Medical History:	**Age**	**Diseases**	**if deceased, cause of death**
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____

Is there a family history of : □ diabetes □ cancer (what kind) _____ □ heart disease, other

Inherited medical problem: _____

COMPLETED BY: _____

REVIEWED BY: _____

M.D. Signature

SUFFOLK ORTHOPAEDIC ASSOCIATES, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
_____	_____	_____

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form is to be completed in order for this office to better serve your interests in protecting the privacy of your health information. Please complete all sections in order to ensure that your health information is released **ONLY** to the parties you are authorizing.

I, _____, authorize Suffolk Orthopaedic Associates to disclose my protected health information to the parties listed below for purposes other than treatment, payment or healthcare operations. I understand that I retain the right to revoke this authorization and any revocation must be done so in writing to the attention of the Privacy Officer of Suffolk Orthopaedic Associates.

Description of the information to be used or disclosed (check all that apply):

( ) Medical Date / Information as related to:
- ( ) Specific condition(s): _____
- ( ) Specific medication(s): _____
- ( ) Specific procedure(s): _____

Name of person(s) authorized to request my protected health information or to speak with Suffolk Orthopaedic Assoc. regarding my healthcare (i.e. family member or attorney)

_____
_____

Name of person(s) NOT authorized to request my protected health information or to speak with Suffolk Orthopaedic Associates regarding my healthcare:

_____
_____

Purpose(s) of the information (i.e. to assist in care, legal matters):

_____
_____

This authorization permits Suffolk Associates to send the protected health information ONLY to this address or fax number:

_____
_____

Fax Number: _____

This authorization shall remain in effect from the date signed below until _____
(expiration date)

I understand that any information used or disclosed prior to this authorization may be subject to re-disclosure and may no longer be protected health information.

Patient Name: _____ ***Signature:*** _____

Relationship to Patient: _____ ***Date:*** _____

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.
Medical Arts Building
375 East Main Street
Suite #1
Bayshore, NY 11706

OFFICE FINANCIAL POLICY

It is the policy of this office that all services are to be paid for at the time of service. If however, there are extenuating financial circumstances, this office will arrange a payment plan for you.

PLEASE BE ADVISED THAT WE PARTICIPATE WITH THE FOLLOWING INSURANCE PROVIDERS:

Aetna (HMO/PPO/MC)	**Empire Government**	**Island Group Admin.**
Anthem Health	**First Health**	**Medicare/ AARP**
Blue Choice	**Great West**	**Oxford (Freedom & Liberty)**
Blue Cross (Direct HMO/ HMO/ PPO/ POS)	**GHI/ Emblem PPO/CPB**	**TriCare**
Blue Cross Senior Plan (MediBlue)	**HealthNet / PHS**	**United Health Care**
Cigna PPO	**Horizon**	**WORKERS COMP. & NO FAULT**

PLEASE NOTE THAT:

- **NOT ALL DOCTORS PARTICIPATE IN ALL PLANS**
- **YOU ARE RESPONSIBLE FOR ANY CO-PAYMENTS OR DEDUCTABLES THAT MAY BE APPLICABLE TO YOUR INSURANCE PLAN.**
- **IF YOUR INSURANCE COMPANY REQUIRES THAT YOU HAVE A REFERRAL, YOU ARE RESPONSIBLE FOR OBTAINING ONE FROM YOUR REFERRING PHYSICIAN. IF AN ACTIVE REFERRAL IS NOT IN PLACE BEFORE YOU ARE TREATED, YOU WILL BE RESPONSIBLE FOR THE DOCTORS CHARGES.**

Surgical fees and fracture fees will be billed to your insurance company first as a courtesy to our patients, provided this office is furnished with the complete information for billing, and with the stipulation that any balance remaining after the insurance processes payment is the responsibility of the patient or parent/guardian.

Medicare pays 80% of your Medical Bill. Under Medicare Law you are responsible for the remaining 20% and your yearly deductible.

Fracture fees include initial cast application and materials. There may be additional costs for any extra casting. Fracture fees and surgical fees also may include a number of after-care visits. This number varies with each fracture and/or surgery and is determined by the HealthCare Finance Administration. There will be no charge for the included visits, however if x-rays are necessary, there will be a charge for them. Ace bandages and slings are not part of the fracture care. These additional materials are the patient's responsibility.

I have read the above financial policy, understand and agree to abide by it.

X _____

SIGNATURE OF PATIENT (If patient is a minor, signature of PARENT and/or GUARDIAN is required.)
I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE COMPANY TO ASSIST IN THE PROCESS OF THIS CLAIM.