

SIGNATURE ORTHOPEDICS – NEW PATIENT PACKET
INSURANCE INFORMATION

Date: _____ New Patient Update
Referred to this Office by: Patient Physician ER (Hospital) Name of Person/Hospital: _____
Patient's name (Last, First MI) _____ DOB _____ Age ___ Sex ___
Patient Email _____ SSN _____ Marital Status ___ Spouse's Name _____
Patient Address _____ City _____ State ___ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Patient's Employer: _____ Employer's Address: _____

PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)
Name (Last, First MI) _____ Relationship _____ SSN _____ DOB _____
Address _____ City _____ State ___ Zip _____ Phone # _____ Work # _____
Employer's name _____ Employers Address _____
Name (Last, First MI) _____ Relationship _____ SSN _____ DOB _____
Address _____ City _____ State ___ Zip _____ Phone # _____ Work # _____
Employer's name _____ Employers Address _____

INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

Primary Insurance _____ Effective Date _____
ID# _____ Group # _____
Subscriber Full Name _____ Subscriber SSN _____ DOB _____
Secondary Insurance _____ Effective Date _____
ID# _____ Group # _____
Subscriber Full Name _____ Subscriber SSN _____ DOB _____
Other Insurance _____ Effective Date _____
ID# _____ Group # _____
Subscriber Full Name _____ Subscriber SSN _____ DOB _____

INJURY REPORT/NATURE OF INJURY

Worker's Comp Recreational Auto Home Other Date of Injury _____

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INITIAL MEDICAL EVALUATION

Name: _____ Date of Birth: _____

Best ph# number to reach you: _____ Email address: _____

Which is your dominant hand? Right Left Gender: Male Female Height _____ Weight _____

Work status: (check one) Working Retired Student Disabled Other _____

Occupation _____ Employer _____

Race _____ Language _____ Ethnicity _____

Who referred you to our clinic? Self Friend Physician Name: _____

Primary Care Physician: _____ Cardiologist: _____

Reason for visit/Chief Complaint: Please describe injury/complaint & how long condition has been present:

Date of onset injury/symptom _____ Is this work related? YES NO Has it been reported? YES NO

Please list any tests, xrays or therapies tried for current condition: (circle all that apply and give date)

| Imaging (xrays) Diagnostic Testing, (MRI, CT, other _____) | Date Performed | Physical Therapy / Chiropractor / Home Exercise Program | Date Performed | Medications Tried: | Date Performed |
|--|----------------|---|----------------|--------------------|----------------|
| | | | | | |

Past Medical History (Please check all that apply)

NO PAST MEDICAL HISTORY

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Anemia <input type="checkbox"/> Angina <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer Specify type: _____ <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Coronary Artery disease <input type="checkbox"/> Deep Vein Thrombosis (DVT) <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Elevated Lipids (high cholesterol) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Fracture <input type="checkbox"/> Gout <input type="checkbox"/> Headache/Migraine <input type="checkbox"/> Hepatitis/liver disease <input type="checkbox"/> HIV <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Lyme disease <input type="checkbox"/> Myocardial infarction (heart attack) <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Peptic Ulcer disease <input type="checkbox"/> Psoriasis <input type="checkbox"/> Renal disease (kidney disease) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Spondyloarthritis (Spondyloarthritis) <input type="checkbox"/> Stroke <input type="checkbox"/> Systemic lupus erythematosus (Lupus) <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Vascular disease <input type="checkbox"/> Other Medical Problems: _____ |
|--|--|---|--|

Past Surgical History

Type of Surgery

| | |
|--|--|
| | |
| | |
| | |

Current Medications & dosage (if known):

NO Medications *If you brought a list, please ask us to make a copy.*

Name of Medication / Strength / Directions

Name of Medication / Strength / Directions

| | |
|--|--|
| | |
| | |
| | |
| | |

What Pharmacy do you use?

Name : _____ **Location:** _____ **Pharmacy Ph#:** _____

Allergies: (Please name substance & reaction) **NO Known Allergies**

Known DRUG allergies _____

Known FOOD allergies _____

Known METAL allergy: Yes No

Known LATEX allergy: Yes No

Relevant Family History:

Adopted - no family history known

| Relative | Alive | Deceased | Heart Disease | Cancer (Specify type) | Diabetes | High Blood Pressure | Renal disease | Thyroid disease |
|------------|-------|----------|---------------|--------------------------|----------|---------------------|---------------|-----------------|
| Father | | | | | | | | |
| Mother | | | | | | | | |
| Brother(s) | | | | | | | | |
| Sister(s) | | | | | | | | |

Social History:

General Education: High School (If local, list name) _____ College _____

Marital Status: Single Married Separated Divorced Widowed

Tobacco use: Yes No _____ Packs per day for _____ years Quit: Yes No Age when quit: _____

Alcohol use: Yes No Frequency/Amount: _____

Other substance use: _____

Work demands: Sedentary Moderate activity Heavy Labor

Do you exercise regularly? Yes No Describe: _____

What sports or activities do you participate in? _____

Do you have children: Yes No # Sons _____ # Daughters _____

PATIENTS 65 YEARS AND OLDER:

Have you had any falls in the last year? Yes No IF YES, Number of falls: _____

Did the fall(s) result in injury? Yes No IF YES, Details: _____

Do you use an assistive device (walker, cane, wheelchair, etc.)? _____

Have you ever received a Pneumonia vaccine? Yes No IF YES, what month/year? _____

Current Medical Status/Review of Systems: Please circle any you have had recently

| | | |
|-------------------|---------------------|-------------------------|
| Fatigue | Chest Pain | Poor coordination |
| Fever | Leg swelling | Muscle weakness |
| Night sweats | Irregular heartbeat | Seizures |
| Weight gain | Constipation | Tremors |
| Weight loss | Diarrhea | Anxiety |
| Blurred vision | Loss of Appetite | Depression |
| Double vision | Nausea | Insomnia |
| Headache | Vomiting | Rash |
| Ringing in ears | Painful urination | Skin Infections |
| Vertigo | Blood in urine | Skin lesions |
| Vision loss | Cold intolerant | Bleeding |
| Asthma | Heat intolerant | Bruising |
| Cough | Difficulty walking | Environmental allergies |
| Labored breathing | Dizziness | Food allergies |

Name of person supplying information _____ Date: _____

Signature: _____

SIGNATURE ORTHOPEDICS - SIGNATURE MEDICAL GROUP
PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to canceling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

| | | |
|-----------------|--------------------|---------------|
| Full Name _____ | Relationship _____ | Phone # _____ |
| Full Name _____ | Relationship _____ | Phone # _____ |
| Full Name _____ | Relationship _____ | Phone # _____ |

Initial all applicable information:

- Medical/Treatment/PHI including retrieval of medical records and prescription refills
- Lab/Ancillary Testing/Radiology/MRI/Imaging Results
- Billing/Insurance Information
- Authorized to leave message on voicemail or by other designated communication systems
- Other, Describe _____

ADVANCE DIRECTIVES FOR HEALTH CARE *(Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare)*
(If applicable to the practice setting, patient to initial appropriate statement):

- The patient does NOT have an Advance Directive
- The patient has the following Advance Directive(s): _____

and will provide a copy to the attending SMG physician practice

.....

Print Patient's Full Name _____ Patient DOB _____

Print Name of Legal Guardian _____ Relationship to Patient _____

Signature & Date Signed _____ Witness to Signature _____

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PAYMENT POLICIES

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to pay by automated payment card by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. The patient/responsible party or guarantor signing below (“you”) must provide us with the patient’s current and correct medical coverage/insurance/health plan (“health plan”) or other responsible third-party payor.
2. You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).
3. You are responsible for paying any deductibles and co-payments in the amount specified by the health plan as well as non-covered services or other costs not covered by the health plan.
4. Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of who has the legal obligation, or payment obligation under parental custody, divorce, or separation terms.
5. WORK RELATED INJURIES:
 - a. If the patient’s employer has approved treatment, you will not be charged or billed.
 - b. If the patient’s employer does not approve treatment and YOU SELECT US FOR YOUR TREATMENT, you may be billed and you may be responsible for payment of services not approved by the employer.
6. If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
7. We file group health plan claims and by law, must file Medicare claims.
8. If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your statement.

We expect payment in full at time of service for all charges which are not covered by the patient’s health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collection fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

All patients 18 and older must sign, regardless of whether they are on parent or other insurance.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____ Date of Birth: _____

Print Guarantor Name and Relationship to Patient: _____

Signed: _____ Date: _____

Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____