SIGNATURE ORTHOPEDICS

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_____

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_____

PAYMENT POLICIES
SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to automated payment card payments 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, co-payments, 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 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 <u>YOU SELECT US FOR YOUR TREATMENT</u>, 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 bill.**

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 collections 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.

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 & Relationship to Patient: _____

Signed: _____/Date: _____
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____

SIGNATURE ORTHOPEDICS

INITIAL MEDICAL EVALUATION

Name:_____ Date of Birth:_____ Today's Date:_____

Which is your dominant hand? □ Right □ Left Gender: □ Male □ Female Height_____ Weight_____

Race:_____ Ethnicity:_____ Language:_____

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

Occupation_____Employer_____

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

Primary Care Physician: _____ Cardiologist: _____

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

_____

_____

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

Have any x-rays or tests been performed □ YES □ NO Date_____ Facility Name _____

Name of tests: _____

Past Medical History (Please check all that apply)

□ Alzheimer's Disease
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Cancer
Specify type:_____
□ Congestive Heart Failure
□ COPD
□ Crohn's disease
□ Coronary Artery disease
□ Deep Vein Thrombosis (DVT)
□ Degenerative joint disease
□ Depression
□ Diabetes
□ Drug Abuse
□ High Cholesterol
□ Fibromyalgia
□ Fracture
□ Gout
□ Headache/Migraine
□ Hepatitis/liver disease
□ HIV
□ High Blood Pressure
□ Inflammatory bowel disease
□ Lyme disease
□ Myocardial infarction (heart attack)
□ Obesity
□ Osteoporosis
□ Peptic Ulcer disease
□ Psoriasis
□ Renal disease (kidney disease)

☐ **NO PAST MEDICAL HISTORY**

□ Seizure disorder
□ Sleep Apnea
□ Spinal Stenosis
□ Spondyloarthopathy (Spondyloarthritis)
□ Stroke
□ Systemic lupus erythematosus (Lupus)
□ Thyroid disease
□ Vascular disease
□ Other Medical Problems:
_____
_____
_____
_____

Please list the name of the physician who is treating you for any of the following conditions: Diabetes, peripheral neuropathy, atherosclerosis of the arteries in your extremities, Buerger's disease, cardiology or chronic thrombophlebitis.

Name_____ Location_____ Date last seen_____

Past Surgical History (Please specify TYPE of surgery, DATE of surgery, side, etc.): _____

_____

_____

_____

History of MRSA or MSSA: Yes _____ No_____ If yes, where on body_____

Current Medications & dosage (if known): ☐ **NO Medications** *If you brought a list, please ask us to make a copy.*

_____

_____

_____

_____

_____

Allergies: (Please name substance and 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)								
Maternal Grandfather								
Maternal Grandmother								
Paternal Grandfather								
Paternal Grandmother								

Social History:

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

□ Post graduate or other _____

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? _____

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

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

Pharmacy Address: _____

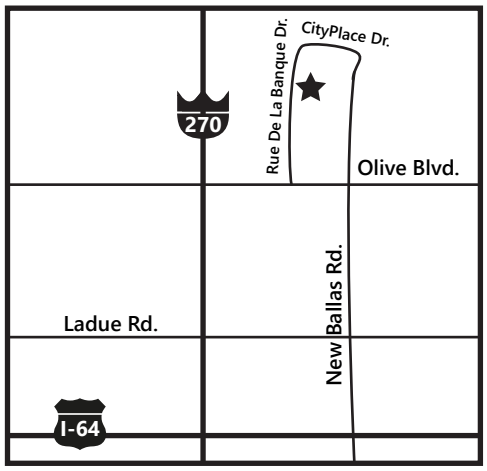
Name of person supplying information_____Date:_____

Signature: _____

Signature Orthopedics

Signature Orthopedics - West County

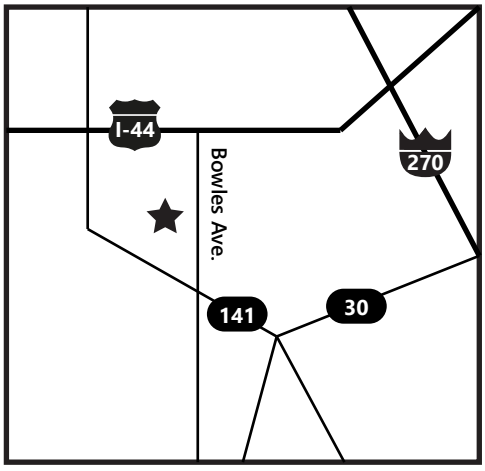
845 N. New Ballas Ct., Suite 200
St. Louis, MO 63141
314.983.4700



If you are traveling south on 1-270, exit Olive Boulevard, exit #14. Turn east, or left, onto Olive Boulevard to the second stop light and turn left onto Ballas Road. Go to the first stop light and turn left onto CityPlace Drive. Go to the first stop sign and turn left onto Rue De La Banque Drive to the parking garage entrance on your immediate left. Continue up the garage to Level 2 (green level) to park. The parking garage entrance on Level 2 will bring you to the second floor.

Signature Orthopedics - Fenton

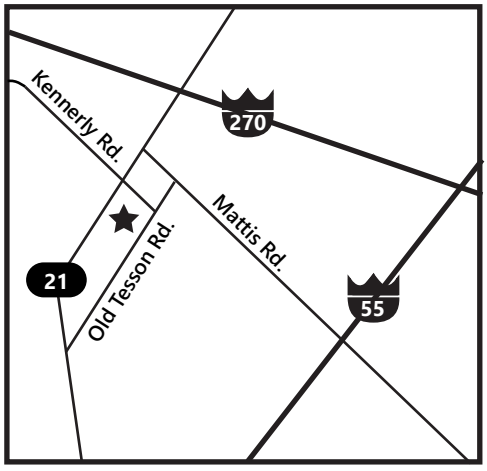
1011 Bowles Ave., Suite 100
Fenton, MO 63026
314.849.0311



If you are traveling east on I-270 S, exit I-44/US-50 W, exit #274A. Merge onto I-44/US-50 W, and take the Bowles Avenue exit on the right. Stay in the middle lane to turn left onto Bowles Avenue at the first stoplight. After turning left, stay on Bowles Avenue until you see SSM St. Clare hospital on the right. Turn right, pass the emergency room and continue on the road until you see the St. Francis building. There is a free parking lot in front of the St. Francis building. Once you walk into the St. Francis building, we are the first suite on the right (Suite 100).

Signature Orthopedics - South County

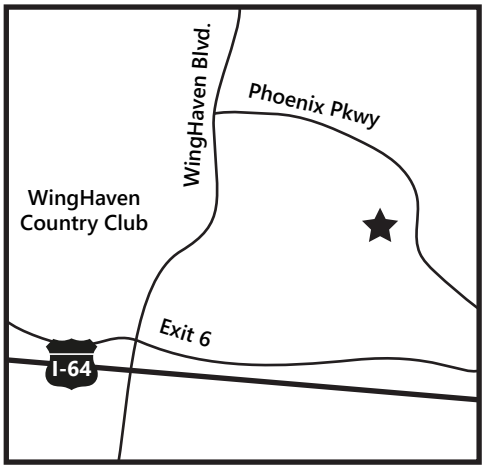
12639 Old Tesson Rd., Suite 100 & 115
St. Louis, MO 63128
314.849.0311



If you are travelling south on I-270, exit on Tesson Ferry Rd. and turn right. Drive 2 lights to Kennerly Road and turn left. Go one block to the stop sign and turn right onto Old Tesson Rd.

Signature Orthopedics - O'Fallon

9323 Phoenix Village Parkway
O'Fallon, MO 63368
314.983.4700



If you are traveling west on I-64/US-40, exit at Winghaven Boulevard, exit #6. Turn north, or right, onto Winghaven Boulevard and go to the third stoplight and turn right onto Phoenix Parkway, which is just past Hammock Court. Take the first right onto Phoenix Village Parkway and the office will be on your left.