

WELCOME TO INTEGRITY ORTHOPEDICS & SPORTS MEDICINE

Patient Name: _____
First Middle Last

Date of Birth: _____ **Email Address:** _____

Home/Cell Number: _____ **Social Security #:** _____

Address: _____
Street City, State Zip Code

Reason for Being Seen Today: _____

Emergency Contact: _____
Name Phone Number Relationship

Is This Visit Related To: (Circle One): An auto accident? YES / NO - OR - An Accident at Work? YES / NO

Primary Care Provider: _____ **Phone Number:** _____

Referring Physician: _____ **Phone Number:** _____

Primary Insurance: _____

Secondary Insurance: _____

I hereby authorize Integrity Orthopedics & Sports Medicine to examine and treat myself or my child and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information required to process my Medicare and/or insurance claims, and for any benefits payable under my policy to be paid directly to Integrity Orthopedics & Sports Medicine. I understand that this may include information related to the diagnosis and/or treatment of alcohol/substance abuse, psychological/mental health disorders, and/or HIV status. I understand that I am responsible for payment of any charges incurred. I accept this responsibility regardless of any reimbursement or coverage. If I am a Medicare beneficiary, I am responsible for paying any charges not covered by Medicare.

Patient Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____

ACKNOWLEDGEMENT - NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled and shared by our practice.

I have reviewed the Integrity Orthopedics & Sports Medicine Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request an accounting of how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed; however, I may not agree with these restrictions if they affect my care. If Integrity Orthopedics & Sports Medicine agrees to my restrictions on the use of PHI, it is bound by that agreement. I have read and understand the information provided above.

Patient/Responsible Party Signature

Date

PATIENT COMMUNICATION PREFERENCES

From time to time, in caring for our patients, it may become necessary to contact you by telephone. If you are unavailable when we call, we would like to leave a detailed telephone message (e.g., lab results) when possible. There are also times when you may want us to communicate laboratory results, medications, treatment plans, or billing information to a trusted friend or family member. To protect your privacy, we need your written permission to leave detailed telephone messages on your answering machine, voicemail system, or with a person you designate. This authorization will remain in effect until you rescind it in writing.

_____ **I DO CONSENT** for my healthcare provider to leave detailed telephone messages regarding my personal health information (PHI) using the following options (if no selection is made, it is understood consent to leave detailed messages has not been granted):

ACCEPTABLE CONTACT METHOD FOR MESSAGES:

_____ Home Phone # _____

_____ Work Phone # _____

_____ Cell Phone # _____

_____ A Trusted Friend/Family Member

Name _____

Relationship to Patient _____ Phone # _____

Patient/Responsible Party Signature

Date

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, a summary, or a narrative of my protected health information to the physician(s) or facility listed below.

Please identify the information to be released:

_____ Release entire record -OR- Please Specify: _____

FROM: (Name and address) _____

TO: (Name and address) _____

The identified information will be used for the following purposes:

_____ Continuing care/treatment -OR- _____ Other (please describe): _____

- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I understand that once the information below is released, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.
- I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the practice.

The identified information may be used by or released to Integrity Orthopedics & Sports Medicine.

Patient Signature: _____ **Date:** _____

Signature of person completing this (form if not patient): _____

Relationship: _____ **Date:** _____

Witness (Practice employee): _____ **Date:** _____

CONSENT TO TREAT / RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "healthcare provider(s)" in this document refers to Integrity Orthopedics & Sports Medicine, its agents, employees, members of the medical staff, their agents and employees, and other healthcare practitioners who provide care to patients. I understand that, as part of my healthcare, this organization maintains health records that describe my health history, symptoms, examinations, test results, diagnoses, treatments, and any care plans, including future treatments. I understand that this information serves as:

1. The basis for planning my treatment and care
2. Information used to file my claim with the insurance company (procedure and diagnosis)
3. A means by which a third-party payer can verify that billed services were provided
4. A tool for routine health care operations, including assessing the quality and reviewing the competency of our staff and/or other health care providers.

I understand that I have been provided with the Notice of Privacy Practices, which provides more complete information on uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy or post any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed for payment, treatment, or healthcare operations, and that the organization is not required to agree to the requested restrictions. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already acted on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary during my care.

RELEASE OF INFORMATION

The healthcare provider involved in my care may release information about me that is necessary to substantiate insurance claims.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignments, I hereby authorize any insurance carrier with whom I have a policy to direct to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges not fully covered by the assigned insurance. If such amounts due to healthcare providers are not paid after reasonable notice, the account shall be deemed delinquent, and a service charge shall be added to the amount due. If I default on payment of the account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to Integrity Orthopedics & Sports Medicine for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

I understand that my signature requests payment, and I authorize the release of medical information necessary to process the claim. If other health insurance is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on the approved claim form or cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible amounts are based on the charge determination by the Medicare carrier.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Signature of person completing this form if not patient: _____

Relationship: _____ **Date:** _____

HISTORY AND PHYSICAL FORM

Patient Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Phone# _____

Reason for Being Seen Today: _____

Medication List

Name of Medication	Dose/Frequency	Name of Medication	Dose/Frequency

Medical History (check all that apply):

Disease	Date	Disease	Date	Disease	Date	Disease	Date
Arthritis		Gall bladder		Hiatal Hernia		Pulmonary Embolism	
Asthma		Glaucoma / Cataracts		High Cholesterol		Stroke/ TIA	
Cancer		Gout		Hypertension		Tuberculosis	
CHF/ CAD		Heart Attack		Kidney Disease		Thyroid	
DVT/ Deep Vein Thrombosis		Heart Failure		Obstructive Sleep Apnea		Ulcers	
Diabetes		Heart Murmur		Pacemaker		Varicose Veins	
Emphysema		Hepatitis		Peripheral Artery Disease		Other:	

Allergies? _____ Latex Allergy? Yes / No

Prior Surgeries, Hospitalizations, or Orthopedic Procedures

Type of Surgery or Procedure	Hospital	Date

Family History

(Heart Disease, Heart Attack, Stroke, Hypertension, High Cholesterol, Coronary Artery Disease, Kidney Disease, Diabetes, Cancer, etc.)

Mother		Deceased?	Yes / No
Father		Deceased?	Yes / No
Children		Deceased?	Yes / No
Siblings		Deceased?	Yes / No

Do You Smoke? Yes/ No How Much? _____ Former Smoker? Yes / No Year Quit: _____

Do You Drink Alcohol? Yes / No Frequency? _____

Height _____ Weight _____

Review of Systems (check all that you are currently experiencing):

CONSTITUTIONAL		EYES		ENT	
☐	Fever / Chills	☐	Blurred vision	☐	Ear pain or hearing loss
☐	Generalized weakness	☐	Loss of vision	☐	Ulcers in the mouth
☐	Headaches	☐	Eye pain	☐	Painful/difficult to swallow
CARDIOVASCULAR		NEUROLOGICAL		ENDOCRINE	
☐	Chest pain / Palpitations	☐	Headaches	☐	Diabetes
☐	CABG/ CAD/ CHF	☐	Dizziness/ weakness	☐	Thyroid
☐	Aneurysm	☐	Balance issues	☐	Excessive hunger/thirst
GENITOURINARY		INTEGUMENTARY		PSYCHIATRIC	
☐	Enlarged prostate	☐	Rash/itching	☐	Anxiety
☐	Blood in urine	☐	Ulcers/ wounds	☐	Depression
☐	Painful/frequent urination	☐	Hair or nail changes	☐	
PERIPHERAL VASCULAR		GASTROINTESTINAL		MUSCULOSKELETAL	
☐	Leg cramps/ swelling	☐	Bloody stool / rectal bleed	☐	Arthritis
☐	Foot pain at night	☐	Nausea & vomiting	☐	Joint pain/stiffness
☐	Redness/ open wounds	☐	Weight changes	☐	Difficulty walking
☐	Coldness in extremities	☐	History of GI Bleed	☐	
RESPIRATORY		ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW:			
☐	Asthma				
☐	COPD/ emphysema				
☐	Obstructive Sleep Apnea				
☐	Snoring				
☐	SOB				

Patient Signature: _____ Date: _____