



Dear Patient:

We welcome you to OrthoSports, LLC, the office of Dr. Brian Oliver. Our goal is to make sure you have a pleasant experience as we appreciate the opportunity to provide orthopaedic care to you. This letter will serve as an introduction to our practice and provide an overview of our policies and procedures.

NEW PATIENTS- If you are a new patient to our practice, please arrive 20 minutes prior to your scheduled appointment. This will allow time for checking in and new patient paperwork to be completed. If you have Internet access, we encourage you to print our new patient forms at your leisure and bring them to your appointment. If you are unable to arrive early, we may need to reschedule your appointment to a more convenient time. Please make sure to bring with you the following; insurance cards, driver's license or ID card, referral for your visit (if applicable), and any xrays or MRIs for the problem we will be evaluating. Please bring the above items to check in at the front window.

PRACTICE HOURS- Our hours of operation are from 8:30 am to 5:00 pm, Monday through Thursday and 8:30 am to 12:00- noon on Friday. For emergency care, we are available 24 hours a day, 7 days a week. Occasionally, an emergency may arise and will cause scheduling problems or delays. We ask your understanding, and we will reschedule you to the earliest available appointment with your physician, physician assistant or nurse practitioner.

TELEPHONE CALLS- Any patient with a problem is encouraged to call us anytime day or night. The office staff has been trained to answer many questions and/or the staff will relay information to the medical staff. We will return all calls at our earliest convenience.

PRESCRIPTIONS- Most prescriptions can be renewed by telephone with the exception of certain narcotics. In addition, it is our policy to not renew medications, even for chronic ailments, if the patient has not been evaluated within the year. Medications will be refilled during the hours of 8:30 am and 4:00 pm, Monday through Thursday and 8:00 am to 12:00- noon on Friday. When calling for a prescription refill please, make sure to have your pharmacy name and pharmacy phone number available for our staff. NO medications will be dispensed after hours or on weekends.

FEES AND PAYMENTS- Copayments and coinsurance payments are collected at the time of service. Most major credit cards are accepted. If special circumstances or payment arrangements are needed please, make prior arrangements with one of our billing representatives. Please be advised that we do charge a \$25.00 no show fee for all appointments that are not cancelled within 24 hours of the appointment time. There is also a \$25.00 NSF fee for all returned checks.

INSURANCE- Please, make sure to bring your insurance cards with you to all office visits. If your insurance has changed since your last visit with us please, notify our front office staff so that we may bill the appropriate insurance carrier for your visit. Failure to notify our office of insurance changes may result in the office visit or surgery being cancelled or the patient being held responsible for any remaining balance.

FORMS- If you require a form to be filled out for insurance reasons, short term or long term disability, workers compensation, FMLA or any form that is manually produced there is a fee of \$5.00 per page which is payable in advance for each form. Please allow 7-10 business days for completion of your form.

Thank you for your cooperation in following our office policies and procedures. We look forward to assisting in your orthopaedic needs in the near future.



NEW PATIENT INFORMATION FORM

Patient: _____ **Today's Date:** _____
Last Name First Name MI

If patient if a minor, Parent's name(s): _____ **Patient's SS#** _____

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

City: _____ **State:** _____ **Zip:** _____ **Age:** _____ **Sex:** M F

Summer address: _____ **Marital Status:** S M D W Sep

Hm Ph: _____ **Cell/Other:** _____ **Wk Ph:** _____

Employer: _____ **Occupation:** _____

Primary care physician: _____ **Ph:** _____

****INSURANCE INFORMATION****

Primary Insurance: _____ **Name of Insured:** _____

Relationship to Insured: Self Husband Wife Child Other **Insured D.O.B.** _____

Insured Social Security/ID #: _____ **Grp#** _____

Secondary Insurance: _____ **Name of Insured:** _____

Relationship to Insured: Self Husband Wife Child Other **Insured D.O.B.** _____

Insured Social Security/ID #: _____ **Grp#** _____

Is the patient currently in a skilled nursing facility (SNF) ? Yes No
If yes, name of facility? _____ **Ph:** _____

Please list the name of the primary person to contact in case of emergency regarding your medical condition:

Name: _____ **Relationship:** _____ **Phone:** _____

Please list the name(s) of other family and/or friends that we may inform about your medical condition:

Name: _____ **Relationship:** _____ **Phone:** _____

This is an acknowledgement that the information provided is accurate to the best of my knowledge.

Patient or Designated Representative Signature **Printed Name** **Date**

COORDINATION OF BENEFITS FORM

Dear Patient:

In many cases insurance carriers will coordinate medical benefits with other insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. Please take a moment to complete the following information so that we may expedite your claim process.

Patient Name: _____ Subscriber's Name: _____
Patient ID#: _____ Group Name and #: _____

SECTION 1- COMPLETE THIS SECTION- IF SECTIONS 2 AND 3 ARE NOT APPLICABLE PROCEED TO SECTION 4.

Date of visit: _____ Referred by: _____

What are we seeing you for today? _____

Is the reason for your visit due to an injury caused by an accident? Yes No

Date of Accident/Injury: _____ Related to: Auto Work School Other

How, when and where did the accident occur? _____

If no, please explain the problem: When did the problem start? _____

Was a third party responsible for your injury? Yes No

If yes, please provide the following: Name and address of individual or company

Are you currently working? Yes No If no, last date that you worked? _____

Do you have an attorney? Yes No

If yes, name and phone number: _____

SECTION 2- COMPLETE ONLY IF YOUR SPOUSE IS THE INSURED FOR THE PRIMARY INSURANCE

Full name of your spouse _____ SS# _____

Spouse's employer _____ DOB: _____

Is your spouse covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

SECTION 3- COMPLETE ONLY FOR CHILDREN UNDER 18 AND/OR FULL TIME STUDENTS

Full name of father _____ SS# _____

Father's DOB: _____ Father's employer: _____

Is your father covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

Full name of mother _____ SS# _____

Mother's DOB: _____ Mother's employer: _____

Is your mother covered by any health insurance company? Yes No

If yes, please provide name of insurance carrier _____

SECTION 4

Is your problem covered by any other insurance? Yes No

To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes my insurance to receive any and all information concerning claims filed by me or on my behalf to another insurance carrier.

Patient or Designated Representative Signature

Printed Name

Date

NOTICE OF PRIVACY PRACTICES- EFFECTIVE APRIL 14, 2003

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

OrthoSports, LLC has always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by the doctor who referred you to us or a doctor we have referred you to see.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a transcription service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will be become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509 F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing your complaint, please contact our Privacy Officer, Karen Horn at 727.725.6231 for further information.

This is an acknowledgement that I have received a copy of the Notice of Privacy Practices for the office of OrthoSports, LLC.

Patient or Designated Representative Signature

Printed Name

Date

PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our practitioners, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amount, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept NO excuses for their loss, theft, and will not order replacements. We will not prescribe them if you are using them other than exactly prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first store may be cancelled.

Many prescription drugs are appropriate for short term use only. If and when we feel it is not in your best interest to continue on a medication we will let you know. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24- 48 hour call-in policy of the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call our office. Make sure to provide us with the name of your pharmacy, pharmacy phone number and the type of medication you are taking. You must allow us 24- 48 hours so that we will have time to ask your practitioner and then call in the medication to your pharmacy. Prescriptions will not be refilled after 12:00 pm (noon) on Fridays or on weekends.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR) or the local police. Accepting treatment and /or a prescription by one of our practitioners therefore indicates that you are in agreement with this policy and will abide by these terms.

This is an acknowledgement that I have received and understand the prescription drug policy for the office of OrthoSports, LLC.

Patient or Designated Representative Signature

Printed Name

Date

FINANCIAL POLICY

Thank you for your confidence in choosing OrthoSports, LLC for your orthopaedic needs. Our staff is committed to ensuring that your medical care and treatment is a mutually satisfying experience. Since payment of your bill is part of your treatment, we want to be sure that our financial policies are clearly understood before we begin treatment. Please read, sign and date the following financial policy and ask any questions that you may have prior to your appointment.

Full payment is required at the time services are rendered. For your convenience we accept cash, check and all major credit cards.

Our practitioners are providers for many managed care insurance companies; however you are ultimately responsible for any co-payments, coinsurance and/or deductibles at the time services are performed. We will gladly file your insurance claim to your insurance carrier for all companies with whom we are contracted with. If we are not contracted with your insurance company, you will be required to pay for services as they are rendered. We will provide you with all the information necessary to file your claim and receive reimbursement directly from your insurance company.

Payment of your account is your responsibility regardless of your insurance coverage. Your insurance is a contract between yourself and the insurance carrier. We are not a party to that contract. If your insurance does not pay your claim within 45 days, any balance due will become your responsibility.

Please be aware that your insurance company will pay only for services they regard as “reasonable and necessary” according to the guidelines of your particular policy. You will be responsible for payment of any non-covered service in full including any non-covered durable medical equipment (i.e. braces, crutches, walkers, cast shoes, arm slings, ace wraps, cold therapy machines, casting material, etc)

Patients who are scheduled for surgery will be required to pay any co-payments, coinsurance and/or deductibles prior to the surgery. If we are not contracted with your insurance company or you do not have coverage, a 50% deposit of the estimated cost of your surgery will be required. The balance will be due within 30 days following surgery.

I agree to pay any balance not paid by my insurance carrier. I agree to any necessary fee involved with collection of this account should it become delinquent. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to be made to the party who accepts assignment.

I have read and agree to abide by the financial policy set forth by the office of OrthoSports, LLC

Patient or Designated Representative Signature

Printed Name

Date

MEDICAL ASSIGNMENT OF BENEFITS, AUTHORIZATION FOR TREATMENT AND PAYMENT RESPONSIBILITY

THE UNDERSIGNED hereby authorizes OrthoSports, LLC ("Provider") to render treatment to patient. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of services.

THE UNDERSIGNED hereby certifies that all information provided to Provider by the undersigned or patient including any information in connection with applying for payment under title XVIII of the Social Security Act is true and accurate in all respects

THE UNDERSIGNED hereby authorizes Provider to disclose any information, furnished to Provider or obtained by Provider in connection with patient's treatment (including information concerning a related Medicare claim) to any governmental agency (including Social Security Administration or any of its intermediaries or carriers, insurance company or health care facility requesting such information.

THE UNDERSIGNED hereby assigns Provider all Medicare benefits to which patient may be entitled for any services rendered by Provider. In addition, the undersigned approves contact with appropriate family members for medical purposes.

THE UNDERSIGNED hereby assigns to Provider all private medical insurance benefits (primary and secondary, including medi gap providers) or other benefits to which patient may be entitled for any services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file all such benefits on behalf of patient.

THE UNDERSIGNED agrees that the undersigned shall be ultimately financially responsible for any portion of Provider's claim that is not paid. The undersigned understands that Medicare or any health maintenance organization (HMO) may deny some charges that the physician deems necessary. Medicare and other HMO's have been denying payment for some soft goods and services (i.e. braces, crutches, walkers, cast shoes, arm slings, ace wraps, cold therapy machines, casting material, etc). The undersigned agrees to be responsible for payment of these charges should they be denied for payment. Payment of your account is your responsibility regardless of your insurance coverage. If your insurance does not pay the Provider's claim within 45 days, any balance due will become the undersigned or patient responsibility.

THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of patient.

THE UNDERSIGNED agrees that the provisions hereof shall continue in full force and effect until provider has received written notice of termination signed by the undersigned; however the above mentioned paragraphs 2, 4, 5 and 6 shall survive any such termination.

THE UNDERSIGNED grants permission for the Provider to treat the undersigned and/or minor child and/or dependent. If minor, parent and/or guardian must be present at time of first visit. If minor is returning for the same injury or problem, parent and/or guardian does not have to be present, however a signed consent to treat letter will need to accompany the minor.

THE UNDERSIGNED agrees that treatment by the Provider will not be construed as willingness on the part of the Provider to be a witness in a personal injury litigation case.

THE UNDERSIGNED understands that confabulation or fabrication either by commission or omission will be sufficient reason for unilateral discontinuation of treatment and cancellation of any contract either expressed or implied.

THE UNDERSIGNED agrees that xrays and laboratory tests are the property of the Provider and the fees charged for these services are the processing and interpretation. These records or their copies will be released at the discretion of the Provider. A nominal fee may be charged to cover additional expense for their release.

Patient or Designated Representative Signature

Printed Name

Date

COMPREHENSIVE ORTHOPAEDIC HISTORY (PAGE1)

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

The current problem is the result of: (please circle all that apply) **Auto** **Worker's Comp.** **Other:** _____

LIST ANY AND ALL MEDICATIONS – NOT JUST ORTHOPEDIC RELATED MEDICATIONS

Medication	Dose	Reason	Medication	Dose	Reason

DO YOU HAVE ANY ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS AND/OR SHELLFISH? **YES** **NO**

Are all immunizations up to date? **Yes** **No** If no, which are due? _____

PAST MEDICAL HISTORY – LIST ALL MEDICAL HISTORY NOT JUST ORTHOPEDIC RELATED

Surgery/Hospitalizations/Fractures	Year	Complications

Have you ever had general anesthesia? **Yes** **No** If yes, any problems with anesthesia? **Yes** **No**

SOCIAL HISTORY

<input type="checkbox"/> Work in the home	<input type="checkbox"/> Employed (occupation _____)	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed			
Do you have children?	Yes No	How many?	1 2 3 4 5 Other: _____
Do you live alone?	Yes No	Exercise?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never
Why type of exercise?			
History of substance abuse? Yes No		What?	
Smoke currently?	Yes No	_____ packs per day for _____ years	
Quit smoking?	<input type="checkbox"/> This year	<input type="checkbox"/> > 1 yr	<input type="checkbox"/> > 5 yrs <input type="checkbox"/> > 10 yrs- smoked _____ packs per day for yrs
Drink alcohol?	<input type="checkbox"/> Daily	<input type="checkbox"/> 1- 2 x/wk	<input type="checkbox"/> 1- 2 x/mo <input type="checkbox"/> 1- 2 x/year <input type="checkbox"/> No, I do not drink
Are YOU or have YOU ever been a victim of domestic violence? Yes No			

