ORTHOPAEDIC SPECIALISTS OF MASSACHUSETTS

Patient Information

Name:_____ **Address:** _____

Telephone#: _____ **Work #:** _____**Cell #:** _____

DOB: _____ **Age:** _____

EMAIL: _____

Primary Care physician: _____ **Phone#:** _____ **Fax:** _____

Pharmacy Name: _____ **Phone #:** _____ **Fax:** _____

Address: _____ **City/ State/ Zip:** _____

Person to Notify in case of emergency: _____**Phone#: (____)** _____-_____

Insurance Information:

Primary Insurance: _____ **ID#:** _____

Policy Holder: _____**DOB:** _____/____/____

Relationship to patient: □ **Self** □ **Spouse** □ **Child** □ **other**

Secondary Insurance: _____ **ID#:** _____

Policy Holder: _____**DOB:** ___/____/____

Work related injury: □ Yes □ No If yes, Name & address of responsible party:

Insurance Name: _____

Auto related injury: □ Yes □ No Address: _____

Claim#: _____ Adjuster: _____

Date of Accident /Injury: ____/____/_____ Telephone#: _____Ext: _____Fax_____

AUTHORIZATION OF BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the above named physician of medical/ surgical benefits, if any, Otherwise payable to me for services.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named physician to release any information acquired in the course of my examination or treatment.

HIPAA: Notice of Privacy Practices
My signature below indicates that I have been provided with a copy of the Notice of privacy practices.

Patient's signature: _____**Date:**__ ___/_____/_____

PATIENT PERSONAL HISTORY -PAGE 1

Name: _____ Date of birth: _____ Height: _____ **Weight**: _____

Brief description of your problem and when it began: _____

_____

Race: _____Decline **Ethnicity:** _____Decline **Language**: _____Decline

***MEDICATIONS*: Please use back of page if you need more room.**

Name	*Dosage*	*Frequency*	*Name*	*Dosage*	*Frequency*
1._____			2._____		
3. _____			4. _____		
5. _____			6. _____		

***ALLERGIES*:** □ Yes No (please list) **LATEX ALLERGY:** Yes No Please use back of page if you need more room.

1._____2_____3_____4_____

***Please list ALL prior operations*:** _____

***Please list ALL prior hospitalizations*:** _____

Have you had any complication with ANESTHESIA? Yes No

If yes please explain: _____

***Immunizations*:** Last tetanus shot (date) _____/_____/_____

***Please circle Yes or No*:**

History of MRSA –Year _____	□Yes □No		
Hypertension (High blood Pressure)	□Yes □No	**Hepatitis**	□ Yes □No
Diabetes	□Yes □No	**HIV & AIDS**	□ Yes □No
High Cholesterol	□Yes □No	**Bleeding or blood disorder**	□ Yes □No
Pacemaker	□Yes □No	if yes, type_____	
Stroke	□Yes □No	**Asthma**	□ Yes □No
Sleep apnea	□Yes □No	**Other Lung disease**	□ Yes □No
Artificial Heart Valve	□Yes □No	If yes, type_____	
Depression	□Yes □No	**Cancer** if yes, type _____	□ Yes □No
Liver disease	□Yes □No	**Heart disease** if yes, type _____	□ Yes □No
Blood Clots (DVT) or pulmonary embolus □ Yes □No			

If yes, When? _____

Please list any other medical issues not listed: _____

FAMILY MEDICAL HISTORY Y N **Cancer**: Y N **Substance Abuse**: Y N **Environmental Exposure:** Y N

If **YES** please list: _____

Patient signature_____ Date_____/_____/_____

ORTHOPAEDIC SPECIALISTS OF MASSACHUSETTS

PATIENT PERSONAL HISTORY –PAGE 2

Name: _____ Date of birth: _____

Social History: □ Single □ Married □ Partnered □ Divorced Widowed

Work Occupation: _____ □ Full time Part time Disabled Retired Unemployed

Tobacco use: Yes No How many packs per day_____ □Year quit smoking_____

Recreational drug use: Yes No (if yes please list)_____

Alcohol use: Yes No Number of drinks per week_____

Caffeinated drinks: Yes No (If yes how many per day)_____

Do you have children? Yes No (If yes, how many) _____

Review of Systems: (please **circle** all that apply)

General:
Feeling well
Fever
Chills
Fatigue

Skin:
Bruising
Rash

Respiratory:
Cough
Wheezing
Difficulty
Breathing

Cardiovascular:
Chest pain
Palpitations
Edema
Phlebitis

Gastrointestinal:
Heartburn/Reflux
Constipation

Psychiatric:
Anxiety
Depression
Insomnia
Dementia

Musculoskeletal:
Calf Pain
Joint swelling Joint Pain
Joint Stiffness
Muscle Weakness
Muscle Pain
Muscle Atrophy
Leg Cramps

Hematology:
Anemia
Blood Clots
Nose Bleeds

Neurological:
Dizziness
Unsteadiness
Weakness
Numbness
Unusual Sensation
Fainting
Headaches

Genitourinary:
Prostate enlargement
Prostate Cancer
Recurrent Urinary Tract Infection

Patient Signature: _____ Date _____/_____/_____

Physicians Signature: _____ Date _____/_____/_____

ORTHOPAEDIC SPECIALISTS OF MASSACHUSETTS

Robert L. Patz , M.D.
Peter E. Mebel, M.D.
Mark J. Messineo, M.D.
Joseph L. Sirois III, M.D.
Stanley Hom M.D.
Peter Dewire M.D.
Alicia M. McKersie, PA-C
Bennett Gale, PA-C

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I _____ consent to: the use or disclosure of my "protected health information" (PHI) as identified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and this Consent by Orthopaedic Specialists of Massachusetts, P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct the health care operations of Orthopaedic Specialists of Massachusetts, P.C. I understand that diagnosis or treatment of me by the physicians(s) and / or physical assistant(s) and / or medical assistant(s) at Orthopaedic Specialists of Massachusetts, P.C. may be continued upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my physician, physician assistant, medical assistant, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health condition and indentifies me, or there is a reasonable basis to believe such information may indentify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the healthcare operations of Orthopaedic Specialists. Orthopaedic Specialists of Massachusetts, P.C. is not required to agree to any restriction that I may request. Orthopaedic Specialists of Massachusetts, P.C. agrees to any restriction requested by me, such restrictions shall be binding on Orthopaedic Specialists of Massachusetts, P.C. and the physician(s) and/ or physical assistant(s) and / or medical assistant(s) at Orthopaedic Specialists of Massachusetts, P.C. I further understand that I have the right to revoke this consent , in writing, at any time, except to the extent that Orthpaedic Specialists of Massachusetts, P.C. and / or physician(s) and / or physical assistant(s) and/ or medical assistant(s) at Orthopaedic Specialists of Massachusetts, P.C. have taken action in reliance on this consent.

I understand I have the right to review Orthopaedic Specialist of Massachusetts, P.C.'s **Notice of Patient Privacy Practices** prior to signing this consent. Orthpaedic Specialists of Massachusetts, P.C. Notice of Patient Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of the health care operations of Orthopaedic Specialists of Massachusetts, P.C. This Notice of Patient Privacy Practices also describes my rights and Orthopaedic Specialists of Massachusetts, P.C.'s duties with respect to my protected health information.

Please also note that as provided in Orthopaedic Specialists of Massachusetts, P.C.'s Notice of Patient Privacy Practices, Orthpaedic Specialists of Massachusetts, P.C. reserves the right to change the privacy practices that are described in such notice. I may obtain a revised Notice of Patient Privacy Practices by calling Orthopaedic Specialists of Massachusetts, P.C.'s Norwood office at: (781) 769-6720 and requesting a revised copy be mailed to the location of my choice, or by asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Patient Financial Policy

At Orthopaedic Specialists of Massachusetts, we are committed to providing you with the best possible care. Our fees for services are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Self-Pay / Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, a deposit of $300 is required on the day of your appointment before being seen by the provider. Any fees remaining will be collected following your appointment.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Following your appointment, as a courtesy we will bill your insurance company, any patient responsibility portions are to be paid upon first receipt of your patient statement. If your insurance does not respond within 90 days the bill will become your responsibility. It is important to notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay in full at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Orthopaedic Specialists of Massachusetts contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you will be required to reschedule your appointment or can sign a waiver claiming responsibility for payment and pay $200 for your office visit (cash, check or credit card). If the insurance referral is received OSM will process the claim and refund any money owed when the claim is paid.

Workers Compensation/Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We do not bill attorneys for medical services.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during the 10 or 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections will be charged separately during this time.

Payment for services may be paid by cash, personal check, or credit card. **Responsible parties** will be responsible for any expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned. ***Please sign that you have read and agree to this Financial Policy.***

Responsible Party Signature: _____ Date: _____

Patient Name (if different from Responsible Party): _____