Markbreiter Orthopedics, - New Patient Information Form

Date:_____
Last Name:_____ First Name (Legal):_____ M.I._____
Address:_____ City:_____ State:_____ Zip Code:_____
Social Security#:_____ Date of Birth:_____ Age:_____
Home#:_____ Cell#:_____
Work#:_____ Email:_____
Sex:☐M ☐F Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Race:_____ Ethnicity:_____ Pref Language:_____

Emergency Contact

Name:_____ Relationship:_____ Phone#:_____
If Patient is a minor-parent's social sec#_____
Referred by: ☐Primary Physician ☐Other Physician ☐Friend ☐Other _____
Your Primary Care Physician:_____ City_____ State_____
Referring Physician:_____ Address_____
City:_____ State:_____ Zip Code:_____ Phone#:_____

Employer Information

Name:_____
Address:_____ City:_____
State:_____ Zip Code:_____ Phone#:_____
Occupation:_____

Current Problem

Please briefly describe:_____
_____
Is problem on your: ☐Right Side ☐Left Side Date of onset:_____

Health Insurance Information

Primary

Carrier:_____ Name of Insured (Policyholder) :_____
Address:_____ ID Number:_____
City:_____ State:_____ Zip Code:_____
Insured's Employer:_____ SS#:_____ DOB (mm/dd/yy)_____

Secondary

Carrier:_____ ID Number:_____
Name of Insured (Policyholder) :_____ SS#:_____DOB (mm/dd/yy)_____
Insured's Employer:_____
Address:_____ City:_____ State:_____ Zip Code:_____

I hereby authorize that payment be made directly to my physician on all insurance submitted by Markbreiter Orthopedics, Inc for covered services rendered. I understand I am financially responsible for any non-reimbursed amounts of my bill. I authorize release of any pertinent medical records and/or X-Rays concerning my care to insurance companies, and/or my attorney of record, and/or Markbreiter Orthopedics, Inc. I also authorize release of medical data that includes re-disclosure of medical information obtained from other providers. I permit a photostat copy of this authorization be used in place of the original.

I certify that the information I have reported with regard to my insurance coverage is correct.

Signature:_____ Date:_____

Medical History Form

Are you: ❑Right Handed ❑Left Handed

Describe any medical treatment you have already received for this problem: _____

_____

List any previous surgeries and dates (Not necessarily related to present problem)

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List All Medications and Vitamins you are Currently Taking

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any Allergies to Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please Complete the following to the best of your ability

Height:_____ Weight:_____ Blood Pressure:_____

Do You Smoke: ❑Yes ❑No How Much?_____ Do you drink?: ❑Yes ❑No Frequency:_____

List All Present Medical Problems

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had problems with

Asthma	❑Yes	❑No
Bladder	❑Yes	❑No
Bleeding Tendencies	❑Yes	❑No
Bowels	❑Yes	❑No
Breathing Difficulties	❑Yes	❑No
Cancer	❑Yes	❑No
Circulation	❑Yes	❑No
Coordination	❑Yes	❑No
Diabetes	❑Yes	❑No
Digestion	❑Yes	❑No
Dizziness	❑Yes	❑No
Emotional Problems	❑Yes	❑No
Epilepsy	❑Yes	❑No
Gall Bladder	❑Yes	❑No
Gout	❑Yes	❑No
Hearing Problems	❑Yes	❑No
Heart Problems	❑Yes	❑No
• Chest Pains	❑Yes	❑No
• Palpitations	❑Yes	❑No
Hepatitis	❑Yes	❑No
Hiatal Hernia	❑Yes	❑No
High Blood Pressure	❑Yes	❑No
Kidneys	❑Yes	❑No
Liver Disease	❑Yes	❑No
Lungs	❑Yes	❑No
Osteoporosis	❑Yes	❑No
Prostate Problems	❑Yes	❑No
Shortness of Breath	❑Yes	❑No
Substance Abuse	❑Yes	❑No
Thyroid	❑Yes	❑No
Ulcer Disease	❑Yes	❑No
Vision	❑Yes	❑No
Water Retention	❑Yes	❑No

Other:_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice Privacy Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

*Fellow of the American Board of Orthopedic Surgeons

OWNERSHIP DISCLOSURE STATEMENT

This is to advise you that the doctors have ownership interests in treatment of Surgery Centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include, but are not limited to: Lakewood Surgery Center.

I have read and under the above.

_____
(Patient Signature)

_____
(Date)

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland, 21244-1850.