



ORTHOPAEDIC ASSOCIATES L.L.P.  
**VIVEK P. KUSHWAHA M.D.**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care M.D.: \_\_\_\_\_ Referring M.D.: \_\_\_\_\_

Explain in detail the reason for your appointment: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_ Do you have an Attorney? **Yes / No**

Is this a result of a Work Injury? **Yes / No** If yes, Date of Injury: \_\_\_\_\_

Is this a result of an Auto Injury? **Yes / No** If yes, Date of Injury: \_\_\_\_\_

Have you had any diagnostic studies? (*i.e. X-rays, MRI, EMG, Myelogram, Diskogram, Bone Scan*)

If so please list all studies and the most recent date: \_\_\_\_\_

Please list all treatment you have had for this problem: (*i.e. physical therapy, epidural steroid injections*)

Have you been seen by a Pain Management Doctor? **Yes / No** if Yes, Who?: \_\_\_\_\_

**Past Medical History: (please circle any that apply)**

HIV	Diabetes	High Blood Pressure	Heart Attack	COPD/Emphysema
Thyroid	Asthma	Coronary Artery Disease	Stroke/ TIA	Hepatitis A / B / C
Cirrhosis	ADHD	Osteopenia/Osteoporosis	Depression	Tuberculosis
Seizures	Reflux	Kidney Disorder/Failure	High Cholesterol	Osteoarthritis
Pacemaker	Gout	Congestive Heart Failure	Bleeding Disorders	Rheumatoid Arthritis
Ulcers	Blood Clot	Peripheral Artery Disease	Arrhythmia	Sleep Apnea

Psychiatric Illness (which): \_\_\_\_\_

Cancer (type of): \_\_\_\_\_ Other: \_\_\_\_\_

**Current Medical Problems: (please circle any that apply)**

Headaches	Blurry Vision	Loss of Bowel Control	Fever	Pain at Night
Hoarseness	Dizziness	Numbness/Tingling	Cough	Leg Swelling
Chest Pain	Palpitations	Loss of Bladder Control	Hay Fever	Depression
Painful Urination	Bruise Easily	Irregular Heart Beat	Chills	
Weight Loss	Heartburn	Shortness of Breath	Frequent Falls	

Continued on other side

**Past Surgical History**

Type of Surgery	Name of Doctor	Date	Name of Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list all medications you are currently taking, including over the counter medications:**

Name	Dosage	Frequency	Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies? (Please list): \_\_\_\_\_

**Substance Use: (please fill in all that apply)**

	Type of	How Often	Date Started	Date Quit
Tobacco	Yes / No	_____	_____	_____
Alcohol	Yes / No	_____	_____	_____
Illicit Drugs	Yes / No	_____	_____	_____
History of Substance Abuse	Yes / No	_____	_____	_____
If Yes, Which Substance?	_____	Date Quit?	_____	_____

**Occupational History**

What is your Occupation? \_\_\_\_\_

Physical requirements of your Job: \_\_\_\_\_

Work Status: (circle)    Full Duty    Light Duty    Retired    Disabled    Unemployed

Unable to work due to illness, when was your last day of Full Duty? \_\_\_\_\_

Continued on other side



**PHYSICAL THERAPY PRESCRIPTION FORM**

Patient: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Evaluate: Treat as necessary \_\_\_\_\_ x/week for \_\_\_\_\_ week(s): \_\_\_\_\_ as needed

Precautions/Special instructions: \_\_\_\_\_

Continuation of previous program: \_\_\_\_\_ Date of surgery: \_\_\_\_\_

AREA: R L	MODALITIES	PROCEDURES	ORTHOPAEDIC SUPPORTS
<input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Sacroiliac <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand	<input type="checkbox"/> As needed <input type="checkbox"/> Hydrocollator packs <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Electrical stimulation <input type="checkbox"/> Paraffin bath <input type="checkbox"/> Ultrasound <input type="checkbox"/> Whirlpool <input type="checkbox"/> T.E.N.S. <input type="checkbox"/> Traction (cervical) <input type="checkbox"/> Traction (lumbar) <input type="checkbox"/> Iontophoresis <input type="checkbox"/> Fluidotherapy <input type="checkbox"/> _____	<input type="checkbox"/> Evaluate & treat per protocol <input type="checkbox"/> Hand/Upper extremity rehab-OT, evaluate/treat <input type="checkbox"/> PROM <input type="checkbox"/> AROM <input type="checkbox"/> Strengthening/Coordination <input type="checkbox"/> Sensory/Motor re-education <input type="checkbox"/> Modalities as needed <input type="checkbox"/> Specific: _____  <input type="checkbox"/> Isokinetic testing <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Ankle <input type="checkbox"/> Back  <input type="checkbox"/> K-T 2000 <input type="checkbox"/> Massage <input type="checkbox"/> ROM/PROM/AROM <input type="checkbox"/> Mobilization <input type="checkbox"/> Gait training <input type="checkbox"/> Neuromuscular re-education <input type="checkbox"/> Home program <input type="checkbox"/> Trigger point ES <input type="checkbox"/> Myofascial release	<input type="checkbox"/> As needed <input type="checkbox"/> Knee sleeve (neoprene) <input type="checkbox"/> Patellar stabilization brace <input type="checkbox"/> Back support pillow <input type="checkbox"/> Ankle support <input type="checkbox"/> Tennis elbow support <input type="checkbox"/> Thigh support <input type="checkbox"/> Lumbo-sacral orthosis <input type="checkbox"/> Home cervical traction <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Splinting as needed <input type="checkbox"/> Shoulder pulley exercise
	<b>SPECIFIC REHAB PROTOCOLS</b>		<b>THERAPEUTIC EXERCISE</b>
	<input type="checkbox"/> S/P Total knee arthroplasty <input type="checkbox"/> S/P Total hip arthroplasty <input type="checkbox"/> S/P ACL reconstruction <input type="checkbox"/> S/P Rotator cuff repair <input type="checkbox"/> S/P Arthroscopy <input type="checkbox"/> Impingement syndrome <input type="checkbox"/> Patella femoral program <input type="checkbox"/> Lateral ankle sprain <input type="checkbox"/> Baseball pitchers program		<input type="checkbox"/> Back rehab program <input type="checkbox"/> Knee rehab program <input type="checkbox"/> Shoulder rehab program <input type="checkbox"/> Cervical rehab program <input type="checkbox"/> Flexibility program <input type="checkbox"/> Isokinetics <input type="checkbox"/> Strengthening <input type="checkbox"/> Coordination <input type="checkbox"/> Pool therapy

This treatment is medically necessary. Duration of therapy will be dependent upon patient's progress, which will be assessed periodically. Please fax a copy of patient's progress report weekly/monthly.

COMMENTS: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

## FRACTURE CARE

In the event that our orthopaedic surgeon diagnoses you or your child with a fracture, the treatment of a fracture includes the clinical exam, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of the benefits may describe it as a “surgery”, but in reality it is not a surgery, but a closed (non surgical) treatment of the fracture.

The charge for this injury is a single charge that includes 90 days for follow up care, also known as the global period. It does not include charges for x-rays or casting materials. You will not be charged for an office visit every time you visit the doctor since this is included in your initial fracture care exam and fees.

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Patient/Guarantor Signature

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Date

**ORTHOPAEDIC ASSOCIATES, L.L.P.**

**FINANCIAL POLICY**

**WELCOME**, and thank you for choosing Orthopaedic Associates, L.L.P. (hereafter known as O.A.) for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

**INSURANCE:** The patient or their guarantor is responsible for payment for services provided by O.A. at the time of service. O.A. will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles or fees for non-covered services are required at the time of service.

**HMO/PPO OR CONTRACTED INSURANCE PLANS:** Each time you make an appointment with an O.A. physician, it is your responsibility to make sure that the physician is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow for 30 days of payment. If the services are not paid, the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

**MEDICARE:** Our physicians are participating Medicare Providers. Medicare pays 80% of their allowable charges after your annual deductible is met. If you have supplemental insurance, we will require a copy of your insurance card.

I have read all the information above, and agree that, regardless of my insurance status, I understand that I am responsible for the balance on my account for any professional services rendered.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Orthopaedic Associates, L.L.P. to release any information acquired in the course of my treatment that may be necessary to process my claim. (I permit a copy of this authorization to be used in place of the original.) In consideration of services rendered, I authorize payment to be made directly to Orthopaedic Associates, L.L.P.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

I have reviewed ORTHOPAEDIC ASSOCIATES, L.L.P.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby give authorization to Orthopaedic Associates L.L.P. to release any or all of my information regarding my medical records to a designation of my choice:

NAME: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICARE PATIENTS**

I hereby acknowledge that I am not a member of any Medicare HMO plan.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **Orthopaedic Associates Financial Services Policy**

Orthopaedic Associates, L.L.P. is here to meet your healthcare needs and assist you in making payment arrangements for our services.

Please read this information carefully and feel free to ask any questions. Remember, we are here to help you.

For all non-emergency and elective treatments and procedures, payment arrangements are made prior to or at the time of service.

### **Medicare**

If, you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% Co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic Associates, L.L.P. will file Medicare and any supplemental insurance claims to your insurance carrier(s).

### **Insurance Claims**

Insurance coverage often has limitations and does not pay in full. You will be asked to pay a deposit towards balances, such as deductibles, co-pays, or other insurance benefit limitations. As a courtesy to you, Orthopaedic Associates, L.L.P. will file your insurance claims to your insurance company.

As an added courtesy, our staff will contact your insurance company to determine and initiate any pre-certification requirements and payable benefits. For any patient responsibility per your insurance carrier, our billing office will contact you prior to surgery to make payment arrangements.

Payment is expected from your insurance company within 30 days. If payment is not received within this time frame or your insurance company denies the claim, Orthopaedic Associates, L.L.P. reserves the right to bill you directly. Orthopaedic Associates, L.L.P. also bills you if there is any balance remaining after the insurance payment and your surgery deposit is applied to the amount.

### **If you don't have medical insurance**

We request payment at the time of service or satisfactory payment arrangements made prior to service.

If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made.

If you have any questions about your account balance, please call our billing office at 877-865-8303 between the hours of 7:30 am and 5:30 pm, Monday through Friday.

**Anesthesia and Hospital Bills**

You may also receive separate bills from one or other physician's offices. These bills may cover such expenses as physician services and/or professional interpretation of tests and X-rays. Questions concerning such bills should be directed to the office of the physician who sent the bill.

**Use of a Physician Assistant or Co-Surgeon**

As deemed necessary by your physician, a physician assistant or co-surgeon may be necessary to provide the highest level of care during a surgical procedure. For such circumstances, you may be required to provide a surgery deposit for this individual in addition to your physician.

By signing this document you are stating that you have read the above material and understand the financial policy of the Orthopaedic Associates, L.L.P.

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date



**ORTHOPAEDIC  
ASSOCIATES, L.L.P.**  
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

BRADFORD A. URQUHART, M.D.  
ALLEN R. CRISWELL, M.D.  
GREGORY P. HARVEY, M.D.  
ROSEMARY BUCKLE, M.D.  
VIVEK P. KUSHWAHA, M.D.  
ALAN J. RECHTER, M.D.  
NAVIN SUBRAMANIAN, M.D.

KATHERINE HARRISON  
ADMINISTRATOR

## CONSENT FOR RADIOGRAPHS/INJECTION

I, \_\_\_\_\_ hereby authorize Orthopaedic Associates  
and staff to perform radiographs of my \_\_\_\_\_.

I, \_\_\_\_\_ hereby authorize Orthopaedic Associates  
and staff to give an injection in my \_\_\_\_\_.

Signed \_\_\_\_\_ Date \_\_\_\_\_



## CONSENT FOR TREATMENT

This facility has on staff a physician in the deliver of medical (Orthopaedic) care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by state board. Under the supervision o a physician, a physician assistant can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care.

“Supervision” does not require the constant physical presence of the Supervising physician, but rather overseeing the activities of an accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/hers education, training and experience. The services may include:

- A. Obtaining histories and performing physical exams
- B. Ordering and/or performing diagnosis and therapeutic procedure
- C. Formulating a working diagnosis
- D. Developing and implementing a treatment plan
- E. Monitoring the effectiveness of therapeutic interventions
- F. Assisting at surgery
- G. Offering counseling and education
- H. Supplying sample medications and writing prescriptions (where allowed by law)
- L. Making appropriate referrals

I have read the above, and hereby consent to the services of a physicians assistant for my health care needs.

**I understand that at any time I can refuse to see the physicians assistant and request to see a physician.**

Name (please print) \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_