

PATIENT HISTORY QUESTIONNAIRE (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____

Height _____ Weight _____ Occupation _____

Date of Injury, or when did you first notice the problem? _____

Type of Injury/Illness? _____

Were you injured on the job? YES NO

Are you currently working? YES NO

What is your job description/duties? _____

History of present Illness/Injury (how did it happen?)

Have you had any previous treatment or tests for this problem? YES NO

If yes, please list what tests or treatment performed _____

Do you have any medical problems? YES NO

If yes, please list all medical problems _____

Have you ever had surgery? YES NO

If yes, what type of surgery and when? _____

Do you take any medications? YES NO

If yes, please list all medications and dosages _____

Are you allergic to any medications? YES NO

If yes, please list all allergies and type of reaction _____

Do you smoke? YES NO If yes, how much? _____

Do you drink alcohol? YES NO If yes, how much? _____

Do you take any illicit drugs? YES NO _____

Patient Signature _____

DO NOT WRITE IN THIS AREA
For staff use only

Signature _____



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
	SPECIFIC REHAB PROTOCOLS		THERAPEUTIC EXERCISE
	<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.

Patient/Guarantor Signature

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 _____