

# RSZ Orthopaedics

## Patient Information *(Please complete ALL sections)*

Revised 03/12

Today's Date: \_\_\_/\_\_\_/\_\_\_

\*\*\*\**(Please supply photo ID)*

SS#: \_\_\_ - \_\_\_ - \_\_\_ First: \_\_\_ MI: \_\_\_ Last: \_\_\_ Suffix: \_\_\_

**Mailing Address:** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Male  Female **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_  Single  Married  Other \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language:  English  other: \_\_\_\_\_ Student:  Yes  No

Personal E-mail: \_\_\_\_\_ **Home:** (\_\_\_\_) \_\_\_ - \_\_\_ **Cell:** (\_\_\_\_) \_\_\_ - \_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_ - \_\_\_

## Employment Information:

Employed  Retired  Other \_\_\_\_\_ Employer Name: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_ - \_\_\_ Work Address: \_\_\_\_\_

*How were you referred to RSZ?*  Internet  Yellow Pages  Friend/Relative  Employer  Other Source \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Phone: (\_\_\_\_) \_\_\_ - \_\_\_

**Pharmacy Name:** \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_ - \_\_\_

## Health Insurance Information *(Please supply ALL insurance cards to receptionist)*

### Insurance No. 1

Name/Address of Insurance Co: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Policy Holder's/Subscriber Name:** \_\_\_\_\_ Address same as Patient

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Home Phone: (\_\_\_\_) \_\_\_ - \_\_\_ \_\_\_\_\_

SS#: \_\_\_ - \_\_\_ - \_\_\_ Insurance Start Date: \_\_\_ - \_\_\_ - \_\_\_ \_\_\_\_\_

(Address if different)

**Subscribers Relationship to Patient:**  Self  Parent  Spouse  Other \_\_\_\_\_

### Insurance No. 2 ( Not Applicable)

Name/Address of Insurance Co: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**Policy Holder's/Subscriber Name:** \_\_\_\_\_ Address same as Patient

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Home Phone: (\_\_\_\_) \_\_\_ - \_\_\_ \_\_\_\_\_

SS#: \_\_\_ - \_\_\_ - \_\_\_ Insurance Start Date: \_\_\_ - \_\_\_ - \_\_\_ \_\_\_\_\_

(Address if different)

**Subscribers Relationship to Patient:**  Self  Parent  Spouse  Other \_\_\_\_\_

## Auto or Workers' Compensation Insurance Information N/A

Auto Related Injury:  Yes  No Work Related Injury  Yes  No Date of Injury \_\_\_/\_\_\_/\_\_\_ State of Injury \_\_\_

If work related; Contact at employer: Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Approved body part/injury to be treated: \_\_\_\_\_

How was the injury sustained? \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjustor Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

# RSZ Orthopaedics

---

Family Physician/Primary Care Provider: \_\_\_\_\_  None

Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Address: \_\_\_\_\_

---

Were you treated at a Hospital/ER/Urgent Care Center for this problem?  Yes  No Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility Name: \_\_\_\_\_ Location: \_\_\_\_\_ X-rays taken:  Yes  No \_\_\_\_\_

Do you have x-rays or other tests with you today (CD, DVD, Films, etc.)  Yes  No \_\_\_\_\_

*Have you been seen previously by RSZ Orthopaedics:*

Dr. Rosenfeld  Dr. Sharps  Dr. Zamarin  Dr. Mauro  Mest,-P.A. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if known)

---

I authorize release of medical information needed to process insurance company claims.

**Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

(Sign here)

I authorize payment to Orthopaedic Surgery and Sports Medicine Group, P.C. (d/b/a RSZ Orthopaedics) for services provided.

**Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

(Sign here)

(Please sign in both requested areas above)

# RSZ Orthopaedics

---

**\*\*\*FOR MEDICARE PATIENTS ONLY\*\*\***

Name of Patient/Beneficiary: \_\_\_\_\_

Health Insurance Claim Number: \_\_\_\_\_

“ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopaedic Surgery and Sports Medicine Group for any services furnished to me by that physician or supplier. I authorized, any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

**Medicare Patient/Beneficiary Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign here)

Name of Patient/Beneficiary: \_\_\_\_\_

Health Insurance Claim Number: \_\_\_\_\_

Medi-gap (secondary insurance to Medicare) Policy Number: \_\_\_\_\_

“I request that payment of authorized Medigap benefits be made either to me or on my behalf to Orthopaedic Surgery and Sports Medicine Group for any services furnished by physician/supplier. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ any information needed to determine these benefits payable for related services.”

**Medi-gap Patient/Beneficiary Signature:** \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign here)

# RSZ Orthopaedics

---

## Financial Policy

The following information will be helpful to you in understanding our billing procedures and payment for services.

Orthopaedic Surgery & Sports Medicine Group (d/b/a RSZ Orthopaedics) requests that you supply us with complete insurance information. We will file your claim with your insurance carrier. If your claim is work related or auto accident related, it is mandatory that you provide us with the Workers' Comp or auto insurance carrier's complete name, address and claim number. We also require your medical insurance information. You are required to assign all insurance payments directly to our office. Should you request your insurance company to pay you directly, you will be required to make full payment at the time of service. You should call your insurance company at the start of treatment to verify if your plan covers x-rays, if needed.

Any portion of your bill, that is denied, and not paid by your insurance carrier will be your responsibility. You are required to pay all co-payments and/or deductibles as required by your insurance policy to RSZ Orthopaedics in a timely fashion. Your insurance coverage is a contract between you and your insurance carrier. It is your responsibility to understand your insurance coverage. However, we will assist you in any way we can to maximize your insurance benefits. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. If the insurance problem cannot be resolved in a timely fashion, we will require you to establish written financial arrangements with us until the insurance is resolved.

Each month you will receive a statement reflecting unpaid insurance and personal balances. Payments for private balances are due within thirty (30) days. If payment on a private balance is not received, we have the right to charge a percentage of interest to your balance to each statement after the initial thirty (30) day period. If you are experiencing difficulty in making payments in full, contact our office to make payment arrangements.

IF YOUR INSURANCE REQUIRES A REFERRAL, IT MUST BE OBTAINED PRIOR TO YOUR VISIT. Insurance companies require a referral at time of service and have strict rules stating treatment is not to be provided without a referral. If referral is not presented at the time of your visit, you will be responsible for payment at the time of service. Likewise, if a claim form is necessary, we are unable to submit your claim without the form.

Checks returned by your bank are subject to a processing fee. If your account is referred for collection, you will be responsible for collection costs of the outstanding balance, together with court costs and reasonable attorneys' fees.

We will provide you with the best medical services that meet the highest professional standards. We firmly believe that a good relationship is based upon understanding and open communication, and it is our desire to avoid any disagreement or misunderstanding over payment for our services.

If you have any questions regarding our policy please contact our Billing Department at (610)993-8037.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.C.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Sign here)

Signature of Parent or Guardian of Minor: \_\_\_\_\_

# RSZ Orthopaedics

## Patient Medical History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Height: \_\_\_\_\_ (inches) Weight: \_\_\_\_\_ (pounds) Age: \_\_\_\_\_ Living Will:  Yes  No

Reason for visit: \_\_\_\_\_ Date of 1<sup>st</sup> Symptom: \_\_\_\_\_

**Rate your overall pain level today on a scale of 1 to 10 (10 being severe): \_\_\_\_\_**

### Personal Medical History – Please check all that apply N/A

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Osteoporosis/ Osteopenia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Gout
<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	Other: _____
<input type="checkbox"/> Seizures/Epilepsy		<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Any Problems w/ Blood Clotting</b>

### Family History – Please check all that apply N/A

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	Other _____
<input type="checkbox"/> TB	<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>Family History of Blood Clotting</b>			

### Social History – Please check all that apply

Student:  Yes  No Marital Status:  S  M  D  W # Children: \_\_\_\_\_ Do you live alone?  Yes  No

Do you exercise?  Yes  No Exercise Frequency:  Daily  Weekly  Monthly  Rarely  Never

Are you on a special diet?  Yes  No Diet Description: \_\_\_\_\_

Tobacco Use:  Yes  No Tobacco Usage: \_\_\_\_\_ # pack \_\_\_\_\_ # day

Former Smoker:  Yes  No Former Dates Smoked: \_\_\_\_\_

Alcohol Consumption:  Yes  No Alcohol Consumption:  Daily  1-2x week  1-2x month

History of Substance Abuse:  Yes  No If yes, please specify: \_\_\_\_\_

### Review of Systems

**Are you currently having any problems with any of the following? Please answer all questions**

Eyes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Numbness/tingling	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Ears, Nose, Throat	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Joint aches/pains	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Lungs/Breathing	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Depression, anxiety, etc.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Digestion, Stomach Problems	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Pregnant	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Bowel Movements	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Other: _____	
Bladder Problems	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	
Heart Problems	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	
Appetite or Weight Change	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	

# RSZ Orthopaedics

**Allergies (Please List) or None:**  **Allergic to Latex**  Yes  No **Allergic to Neoprene**  Yes  No

---

---

---

**Current Medication List (Please List All) or None:**

Drug Name:	Dose:	Prescribing Provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*(use reverse side or attach list if needed)*

**Allergic to any Medications**  Yes  No (Please specify all) \_\_\_\_\_

**Over the Counter Medications/Herbs/Supplements:** \_\_\_\_\_ **or N/A**

**SURGICAL HISTORY: (Please List) or None:**

Type:	Date:	Performing Provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above information on this and the preceding page is true and correct.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_  
**(Sign here)**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Practitioner Signature)

Note: Your signature on these forms represents that you have completed this form accurately and completely and have disclosed all information for our staff to treat you in our offices.

# RSZ Orthopaedics

## ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP

KARL ROSENFELD, M.D., F.A.C.S.      LEWIS S. SHARPS, M.D.D, F.A.C.S.      RICHARD I. ZAMARIN, M.D., F.A.C.S.  
MICHAEL D. MAURO, D.O.                      WILLIAM L. MEST, PA-C

### AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & RECORD RELEASE

As required by the Health Insurance Portability and Accountability Act of 1996 Orthopaedics Surgery & Sports Medicine Group, P.C. (d/b/a RSZ Orthopaedics) may not use or disclosure your health information, except as provided in the Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to this office.

#### AUTHORIZATION SECTION      PLEASE COMPLETE ALL SECTIONS

I, \_\_\_\_\_ (print name) Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ hereby authorize the use and disclosure if the following health information that pertains to me. I approve sensitive information to be disclosed including but not limited to AIDS, HIV infection, Psychiatric Care/psychological assessment, treatment for drug and alcohol, ADHD/ADD – I can revoke this in writing at any time and address it with the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to the information already released in response to the authorization.

#### Orthopaedic Surgery & Sports Medicine Group

I have received/read the HIPAA privacy notice or read such document and privacy information as required by law.  
I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the practice. I future understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that this authorization will automatically expire one year from the last date of service seen by this practice.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Description of Representative's Authority**

\_\_\_\_\_  
**Signature of Witness**

**You have the right not to disclose specific records per the below information. If you authorize all of the items in the box to be disclosed :**  
 **ALL ITEMS**

**Should you wish to not disclose specific information - Check all that apply:**

Records to disclose: Discharge summary \_\_\_ History and Physical \_\_\_ Progress Notes \_\_\_ Operative Notes \_\_\_ Pathology \_\_\_ Laboratory \_\_\_  
Radiology \_\_\_ ECG/EKG/Other Cardio \_\_\_ Emergency \_\_\_ Other- please specify \_\_\_\_\_  
Purpose of disclosure: Referral to specialist \_\_\_ Legal Investigation \_\_\_ Ins. \_\_\_ Disability \_\_\_ Worker's Comp. \_\_\_ Personal \_\_\_

Mail/Telephone calls/e-mails other communications \_\_\_\_\_ I authorize RSZ Orthopaedics that they may mail or leave a message for me on the phone numbers I disclosed on my patient information form.

**I authorize the following persons to make these disclosures of my health information:**

\_\_\_\_\_  
Name(s)

\_\_\_\_\_  
Relationship(s)

\_\_\_\_\_  
Date

#### Office locations:

**Paoli:** 254 W. Lancaster Ave, P.O. Box 968, Paoli, PA 19301 (610)644-7755 FAX (610)644-8290

**Phoenixville:** 100 First Ave, Phoenixville, PA 19460 (610)933-2288 FAX (610)935-1739

**Limerick:** 649 N. Lewis Road, Suite 200, Limerick, PA 19468 (610)495-0099 FAX (610)495-0318

**Bala Cynwyd:** 100 N. Presidential Blvd, Pagoda Building, Bala Cynwyd, PA 19004 (610)644-7755 FAX (610)644-8290

