

RSZ Orthopaedics

Patient Information

Revised 7/10

Today's Date: _____

Name: _____ Gender: M _____ F _____

Date of Birth: _____ Age: _____ Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Telephone: _____ Mobile: _____ E-Mail: _____

Emergency Contact Name: _____ Phone: _____

Employer: _____ Telephone: _____

Address: _____
Street City State Zip

Health Insurance Information

Name of Insurance Co: _____

Policy Holder's Name: _____ Date of Birth: _____

ID: _____ Group #: _____ Relationship to Patient: _____

Employer: _____

Auto or Workers' Comp Insurance Information

Auto Related Injury _____ Work Related Injury _____ Date of Injury _____ State Injury occurred _____
Complete only if not PA

How was the injury sustained? _____

Claim #: _____ Adjustor: _____

Insurance Co: _____ Telephone: _____

Address: _____
Street City State Zip

Family Physician: _____ Telephone: _____

Address: _____
Street City State Zip

Were you treated at a Hospital or Emergency Room? Yes _____ No _____ Date: _____

Hospital Name: _____ X-rays taken: Yes _____ No _____

Have you been seen by Dr.: _____ Date: _____

I authorize release of medical information needed to process claims.

Signature: _____

I authorize payment to Orthopaedic Surgery and Sports Medicine Group, P.C. for services provided.

Signature: _____

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MEDICARE PATIENTS ONLY

Name of 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.”

Beneficiary Signature: _____ Date: _____

Name of Beneficiary: _____

Health Insurance Claim Number: _____

Medigap 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.”

Beneficiary Signature: _____ Date: _____

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

Orthopaedic Surgery & Sports Medicine Group 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. 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, interest charges of 5% will be added 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 \$25.00 processing fee. If your account is referred for collection, you will be responsible for collection costs in the amount of 30% 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.

Signature: _____ Date: _____

Signature of Parent or Guardian of Minor: _____

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Medical History

Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____ Living Will: Yes ~~Yes~~ No

Personal Medical History – Please check all that apply:

| | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV Positive | Any Problems w/ Blood Clotting ___Y ___N |
| | | Family History of Blood Clotting ___Y ___N |

Other Illnesses: _____

Family History – Please check all that apply:

| | | |
|---------------------------------|--|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <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 |

Social History

Employed: Yes No Occupation: _____

Student: Yes No Marital Status: S M D W Children: No Yes # _____

Do you live alone? Yes No

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

Are you on a special diet? Yes No Describe: _____

Tobacco Use: Yes No Usage: less than pack/day pack/day more than pack/day

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

History of Substance Abuse: Yes No If yes, specify: _____

Recreational Drugs: Yes No If yes, specify: _____

Review of Systems

Are you currently having any problems with your:

| | | |
|---------------------------|------------------|---|
| | <u>Check One</u> | ALLERGIES: (Please List) NONE: _____ |
| Eyes | Yes – No | _____ |
| Ears, Nose, Throat | Yes – No | _____ |
| Lungs, Breathing | Yes – No | _____ |
| Digestion, Stomach Issues | Yes – No | MEDICATIONS: (Please List) NONE: _____ |
| Bowel Movements | Yes – No | _____ |
| Bladder Problems | Yes – No | _____ |
| Heart Problems | Yes – No | _____ |
| Appetite or Weight Change | Yes – No | _____ |
| Bleeding Problems | Yes – No | SURGICAL HISTORY: (Please List) NONE: _____ |
| Numbness/tingling | Yes – No | _____ |
| Joint aches/pains | Yes – No | _____ |
| Depression, anxiety etc | Yes – No | _____ |
| Epilepsy/Seizures | Yes – No | ARE YOU PREGNANT YES NO |
| Hepatitis | Yes – No | LATEX ALLERGY YES NO |

I certify that the above information is true and correct.

PATIENT/GUARDIAN SIGNATURE: _____

Reviewed by: _____ M.D. Date: _____

RSZ Orthopaedics

KARL ROSENFELD, M.D., F.A.C.S.

LEWIS S. SHARPS, M.D., F.A.C.S.

RICHARD I. ZAMARIN, M.D., F.A.C.S.

DAVID RAAB, D.O.

MICHAEL MAURO, D.O.

WILLIAM L. MEST, P.A.-C.

NOTICE, CONSENT, AND RESTRICTION REQUESTS

Patient's Name: _____

Date of Birth: _____ Patient SS#: _____

As required by the **Health Portability Act of 1996**, RSZ Orthopaedics may not use or disclose your health information without your authorization. Your signature on this form indicates you are giving permission for the uses herein. You may revoke this authorization at any time.

Please check

SPECIFIC AUTHORIZATIONS

I give my permission to RSZ Orthopaedics to use my address, phone number and clinical information to contact me, and or other physicians, and or my employer (if work related) with appointment changes, surgery scheduling, prescription messages, test results, laboratory results, and or, other related health information.

If RSZ Orthopaedics contacts me by phone, I give them permission to leave a phone message on my answering machine, voice mail, or cellular phone.

I give the following people permission to: accompany me during my appointment, pick up prescriptions, x-rays, CAT scan, bone scan, MRI, and or other films, disability forms, work status forms, school forms, and or, act on my behalf regarding my health care condition that pertains to my treatment with RSZ Orthopaedics.

Patient Signature: _____ Date: _____