THE CENTER FOR

Sports Orthopaedics, P.C.

Arthroscopic & Hand Surgery • Joint Reconstruction Surgery

Patient Last Name: _____ First _____ Middle_____ ☐ **Male** ☐ **Female**

Address: _____
Street Apt. No. City State Zip

Billing Address (if different) _____
Street Apt. No. City State Zip

Date of Birth ____/____/____ Age _____ **SS#** _____/_____/_____

Primary Phone (____) ____-_____ ☐ Cell ☐ Home **Secondary Phone** (____) ____-_____ ☐ Cell ☐ Home

Primary E-Mail Address: _____

Do you authorize The Center for Sports Orthopaedics S.C. to leave confidential messages on your primary Phone? ☐ Yes ☐ No

Employer _____ Work Phone (____) _____-_____ Occupation _____

Allergies _____

I was referred to your office by:

☐ ER St.Alexius Medical Center
☐ ER Glen Oaks Hospital
☐ ER Northwest Community
☐ Insurance
☐ ER Alexian Brothers
☐ Sherman/Advocate
☐ Physician *(name)* _____
☐ Other (please specify) _____
☐ Urgent Care
☐ Occupational Health

Primary Physician Name _____ Phone (____) ____-_____

Is the Condition a result of an Accident/Injury? ☐ Yes ☐ No **Date of Injury** _____/_____/_____

How did this happen? _____

Is the injury a result of ☐ Workman's Comp ☐ Auto Accident ☐ Other _____

If this injury is work related have you filed a claim with your employer? ☐ Yes ☐ No
Employer Contact _____ Phone (____) _____-_____
Insurance Company _____ Claim # _____
Adjuster _____ Phone (____) ____-_____ Fax (____)____-_____

*** **If Insurance Information is Incomplete Patient will be Billed** ***

Primary Insurance

Insurance Co. _____
Policyholder's Name _____
Policyholder's Date of Birth ____/____/_____
Policyholder's SS # _____-_____-_____
ID# _____
Policy Group # _____

Secondary Insurance

Insurance Co. _____
Policyholder's Name _____
Policyholder's Date of Birth ____/____/_____
Policyholder's SS # _____-_____-_____
ID# _____
Policy Group # _____

I hereby authorize the doctor to release any information to my insurance company and/or family physician acquired in the curse of my examination or treatment. I authorize benefits to be paid directly to them. **I understand that payment of charges is not contingent upon a settlement of my insurance carrier, and that I am responsible for any and all unpaid balances.** I authorize medical providers with The Center for Sports Orthopaedics, S.C. to perform all treatment and procedures, which they consider necessary or advisable for my benefit upon consultation with the patient or patient's parent or guardian.

_____ ____/____/_____ Relationship ☐ Patient ☐ Parent/guardian ☐ Other
Signature of Patient or responsible Party **Date**

THE CENTER FOR SPORTS ORTHOPAEDICS

Please answer all questions to the best of your ability. Date: _____ / _____ / _____

1.) Patient Name: _____

2.) Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female ☐ Right Handed ☐ Left Handed

3.) **Social History:** Please check: ☐ Married ☐ Widowed ☐ Divorced ☐ Single

4.) Do you smoke? ☐ Yes ☐ No Packs/Day: _____ Number of years you have smoked: _____

5.) Do you drink alcohol? ☐ Yes ☐ No Number of Drinks/Week: _____ Recreation Drug Use? _____

6.) **History:** Which body part is involved? _____ ☐ Left ☐ Right ☐ Both

7.) Check any symptoms that you are having: ☐ Pain ☐ Swelling ☐ Weakness ☐ Instability ☐ Numbness/Tingling

☐ Other Symptoms: _____

8.) When did it begin: _____ Rate your pain on a scale of 1-10 (10 being the worst): _____

9.) Was this caused by an injury? ☐ Yes ☐ No Was the injury job related? ☐ Yes ☐ No

10.) If an injury, is there any litigation pending? ☐ Yes ☐ No

11.) Describe the accident or cause of the injury (if applicable) in detail: _____

_____

12.) What activities make this condition worse? _____

13.) What activities make this condition better? _____

14.) Have you had a similar problem in the past? ☐ Yes ☐ No If yes, describe: _____

_____

15.) Have you seen another health care provider for this problem? ☐ Yes ☐ No

Doctor/Hospital/Urgent Care Facility: _____

16.) Have you had any X-Ray/MRI/CT Scan/Ultrasound/EMG/NCV/Other tests? ☐ Yes ☐ No

If yes, where? _____ Did you bring them with you? ☐ Yes ☐ No

17.) What specific treatment have you had? ☐ None ☐ Medication ☐ Arthritis/Anti-inflammatory medication (Please list medications tried and failed) _____

_____

☐ Brace/Splint ☐ Physical/Occupational Therapy ☐ Ice or Heat ☐ Cortisone Injection

18.) **ALLERGIES:** ☐ None ☐ Medication Allergies: _____

_____

19.) Are you allergic to: ☐ Metal ☐ Latex ☐ Adhesives ☐ Iodine ☐ Other: _____

20.) **Past Family History:** Is there any family history relating to your problem? ☐ Yes ☐ No

If yes, please explain: _____

21. Is your mother alive or deceased? _____ If she is deceased, what was the cause? _____

22. Is your father alive or deceased? _____ If he is deceased, what was the cause? _____

Medication/Dosage	
Surgeries/Year	

Signature of Patient/Responsible Party: _____ Date: _____ / _____ / _____

The physician has reviewed the history as documented: _____ Date: _____ / _____ / _____

THE CENTER FOR SPORTS ORTHOPAEDICS,

PAST MEDICAL HISTORY: Have you ever been treated or are currently being treated for any of the following (PLEASE CIRCLE)

☐ Cardiac (Hypertension / Arrhythmias / Peripheral Vascular Disease / Coronary Artery Disease / Congestive Heart Failure / Palpitations)

☐ Lungs (COPD / Emphysema / Asthma)

☐ Neurologic (Stroke / Migraines / Neuropathy)

☐ Blood Clots / Deep Vein Thrombosis

☐ Anemia / Blood Transfusions

☐ High Cholesterol

☐ Liver (Hepatitis / Cirrhosis)

☐ Diabetes

☐ Osteoporosis

☐ Gastrointestinal (Heartburn / Reflux / Stomach or Intestinal Ulcers)

☐ Endocrine (Thyroid)

☐ Psychiatric (Dementia / Alzheimer's disease / Anxiety / Depression / Bipolar)

☐ Renal (UTI / Prostate / Kidney Disease)

☐ Arthritis (Osteoarthritis / Rheumatoid)

☐ Cancer (type): _____

☐ Other: _____

REVIEW OF SYSTEMS

General: ☐ Weight Loss or Gain ☐ Fatigue ☐ Fever or Chills ☐ Weakness ☐ Trouble Sleeping

GastroIntestinal: ☐ Heartburn ☐ Ulcer ☐ Nausea ☐ Vomiting

Skin: ☐ Rashes ☐ Itching ☐ Dryness ☐ Hair or Nail Changes ☐ Lumps/Bumps

Head: ☐ Headache ☐ Neck Pain ☐ Blurry or Double Vision

Ears: ☐ Earache ☐ Decrease Hearing ☐ Ringing in Ears

Urinary: ☐ Frequency ☐ Urgency ☐ Incontinence

Respiratory/Cardiovascular: ☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ Chest Pain ☐ Palpitations

Vascular: ☐ Leg Cramping ☐ Varicose Veins ☐ Swelling of Hands/Feet ☐ Poor Circulation

Hematologic: ☐ Anemia ☐ Bruise or Bleed Easily

Neurologic: ☐ Dizziness ☐ Confusion ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness/Tingling ☐ Tremor ☐ History of Falls

Psychiatric: ☐ Memory Loss ☐ Suicidal Thoughts ☐ Depression ☐ Anxiety

Musculoskeletal: ☐ Muscle/Joint Pain ☐ Stiffness ☐ Weakness ☐ Back Pain ☐ Joint Swelling

Signature of Patient/Responsible Party: _____ Date: ____/____/____

The physician has reviewed the history as documented: _____ Date: ____/____/____

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask our billing department if you have any questions about fees or Financial Policy.

*** All patients must complete our "Patient Registration Form"**
*** WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.**

UCR (Usual and Customary Rates)

We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays. If you have a supplemental insurance we will bill them directly for you. You will receive a bill after the insurance has paid.

HMO/PPO

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. IF YOU DO NOT KNOW YOUR COPAY YOU MAY USE OUR PHONE TO CALL AND FIND OUT. We are members of many HMO's. Patients will not be billed for their care as long as we have the necessary referrals. PPO patient will be responsible for their co-payment at the time of service and will be billed for any balance the insurance company deems patient responsibility.

WORKERS' COMPENSATION

Patients being seen as a result of a work related injury are still responsible for charges incurred by them. At the time of your visit, we will attempt to verify coverage of your charges by your employer. If we cannot verify coverage, we will bill you directly for your charges. Also, if your employer does not pay for your charges within a reasonable period of time, we will bill you directly.

LEGAL OR ACCIDENT CLAIMS

If you are here as a result of an accident claim, we require payment at the time of service.

FILING INSURANCE CLAIMS

In order to file a claim on behalf of the patient, we must have a copy of the insurance I.D. card and the complete address of where the claim is to be sent. Without this information, you will be billed directly. We file claims for Medicare, Public Aid, HMO/PPO's, Workman's Comp and surgical charges.

No Show/Late Cancellation Policy

This Policy has been established to better serve you as well as all patients. When an appointment is made it removes the ability for other patients to be seen efficiently as possible. No-Shows and late cancellations cause a delay in delivery of health care to other patients.

A "No Show" is missing a scheduled appointment without prior notice. A "Late Cancellation" is canceling an appointment without calling 24 hours in advance of an office visit or 48 hours in advance of a procedure.

A charge of $35.00 will be assessed for each No Show or Late Cancellation less than 24 hours prior to appointment.

A charge of $200.00 will be assessed for each No Show or Late Cancellation less than 48 hours prior to procedure appointment

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is possible. These situations will be addressed on a case-by-case basis.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Questions about your bill should be directed to our billing department 847 884-7771.

_____ _____

Signature of Patient or Responsible Party **Date**

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Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I, _____, hereby acknowledge receipt of The Center for Sports
Print Name
Orthopaedics, P.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available upon my request.

With my consent, The Center for Sports Orthopaedics, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out Treatment, Payment and Healthcare Operations such as missed appointments, insurance items and any call pertaining to my clinical care, including laboratory results.

With my consent, The Center for Sports Orthopaedics, P.C. may mail to my home or other designated location any items that assist the practice in carrying out Treatment, Payment and Healthcare Operations, such as missed appointment letters and patient statements.

With my consent The Center for Sports Orthopaedics, P.C. may transmit my medical records via fax or electronically to assist the practice in carrying out the Treatment, Payment and Healthcare Operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior requests. If I do not sign this consent, The Center for Sports Orthopaedics, P.C. may decline to provide treatment to me.

_____
Patient Name (*print*)

_____
Patient Signature (or signature of person completing form) **Date**

Relationship to Patient (circle one): Patient Legal Guardian Other: _____

_____
Witness Signature Date