COMPREHENSIVE ORTHOPAEDICS, S.C.
Patient Acknowledgement & Record of Disclosures

I, _____, _____ acknowledge that I have received the
Patient Name Date of Birth
written Notice of Privacy Practices from Comprehensive Orthopaedics, SC.

☐ The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

Telephone: _____

☐ Leave message with detailed information

☐ Leave message with call back number only

Alternate Telephone: _____

☐ Leave message with detailed information

☐ Leave message with call back number only

Written Communication

☐ Can mail to Home address: _____

☐ Can mail to Work address: _____

☐ Can fax to this number: _____

I consent to have my personal health information disclosed to:

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

_____
Patient (or Guardian) Signature **Date**

_____
Printed Name

This form MUST be filled out NEATLY & COMPLETELY or it will be considered VOID.

(For Office Use Only):

Above Information Has NOT changed: Signature: _____ Date: _____

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Above Information Has NOT changed: Signature: _____ Date: _____

Comprehensive Orthopaedics, S.C.

Patient Financial Policy

At Comprehensive Orthopaedics, S.C. we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or guarantor** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay a portion at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Comprehensive Orthopaedics, S.C. contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We will bill major medical insurance.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, a deposit of $200 is required on the day of your appointment **before** being seen by the provider. Any fees remaining will be billed to you following your appointment. By initialing here, I acknowledge I have received the Self-Pay agreement. _____

Urgent Care: During our after-hours Urgent Care, our financial policy will revert back to a self-pay/Uninsured status until your Insurance can be verified.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that is accompanying the child will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections are not included in the post-operative period.

Responsible Party: I have read the financial policy and understand that I will be responsible for all Comprehensive Orthopaedics, S.C. charges incurred regardless of my insurance status including expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned.

IN THE EVENT THAT I "NO SHOW" MY APPOINTMENT WITHOUT CALLING THE OFFICE AT LEAST 24 HOURS IN ADVANCE, I UNDERSTAND I MAY INCUR A $50.00 "NO SHOW" FEE. IN ADDITION, COMPREHENSIVE ORTHOPAEDICS, S.C. RESERVES THE RIGHT TO TERMINATE MY CARE FOR NON-COMPLIANCE AT ANY TIME.

Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, or American Express.
Please sign that you have read and agree to this Financial Policy.

Patient Name (Print): _____

Responsible Party Signature: _____ Date: _____

Health History – Comprehensive Orthopaedics

Patient Last Name _____ **First Name**_____ **Sex M F**

Appointment date _____ **Date of birth** _____ **Age**_____

Family doctor_____

How did you hear about us? Doctor Therapist Family/Friend Radio Newspaper Internet Other

Dominant hand R L

Is this work-related? YES NO

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Reason for visit_____

Location of problem _____

When did you notice problem/date of injury? _____

How did it start?_____

_____

_____

What makes the problem worse?_____

_____

What makes the problem better?_____

_____

Have you had this before?_____

_____

How painful is the problem currently? [1(mild) – 10 (severe)] _____

What is the most painful the problem has been? [1(mild) – 10 (severe)] _____

Type of pain (dull, sharp, radiating) _____

_____

Other symptoms _____

_____

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Please do not write in this space. Office use only.

Circle any previous treatment/tests:

X-ray **MRI/CT** **Physical Therapy** **Injection** **Other:**

Past Medical History (please circle all that apply): **NONE**

Diabetes Heart Disease High Blood Pressure Asthma Arthritis Cancer

High Cholesterol Thyroid Disease Ulcers/Reflux Kidney Failure Osteoporosis

Multiple sclerosis Osteoarthritis Bleeding Disorders Fibromyalgia

Other (please list) _____

_____

Past Surgical History (please circle all that apply): **NONE**

Back Surgery Carpal Tunnel Surgery Joint Replacement Arthroscopy

Joint Surgery (list site) _____

Other (be specific) _____

Current Medications (please be specific:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you currently take aspirin or other blood thinning drugs? NO YES _____

Have you ever had a reaction to anesthesia? NO YES _____

Drug Allergies (circle yes or no): NO YES (please list allergies below)

_____ _____ _____

_____ _____ _____

Family History (circle the condition any immediate family member has had):

Osteoporosis Rheumatoid arthritis Osteoarthritis Multiple sclerosis/fibromyalgia

Joint Replacements Problems with anesthesia Back problems Bleeding Disorders

Kidney Failure High Blood Pressure Heart Problems Diabetes

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Please do not write in this space. Office use only.

Social History (circle the following):

Occupation _____Employer _____

Currently working? YES NO Any restrictions at work? _____

Marital Status: Married Single Widowed Divorced

Smoker? NO YES_____ Alcohol? NO YES _____

Recreational Drugs? NO YES_____

(Please note if you currently have had any of the following in the past 12 months that HAVE NOT BEEN addressed by another provider)

Constitutional			**Integumentary**		
Fever / Chills	Yes	No	Skin rash/sores	Yes	No
Weight Loss	Yes	No	Bruising	Yes	No
Weakness	Yes	No	Redness	Yes	No
Other_____			Other_____		
Cardiovascular			**Respiratory**		
Chest pain	Yes	No	Shortness of breath	Yes	No
Palpitations	Yes	No	Wheezing	Yes	No
Fullness in chest	Yes	No	Frequent cough	Yes	No
Other _____			Other_____		
Gastrointestinal			**Allergies/immunologic**		
Abdominal pain	Yes	No	Hay fever	Yes	No
Nausea/vomiting	Yes	No	Pollen/grass allergies	Yes	No
Indigestion/heartburn	Yes	No	Runny nose	Yes	No
Diarrhea/Constipation	Yes	No	Other _____		
Bloody stools	Yes	No			
Other_____					
Musculoskeletal			**Neurological**		
Joint pain/stiffness	Yes	No	Confusion	Yes	No
Back pain	Yes	No	Weakness	Yes	No
Difficulty walking	Yes	No	Numbness/tingling	Yes	No
Lack of strength	Yes	No	Loss of memory	Yes	No
Other_____			Other_____		
Psychiatric			**Hematologic/lymphatic**		
Depression	Yes	No	Swollen glands	Yes	No
Disorientation	Yes	No	Abnormal bruising	Yes	No
Anxious/agitated	Yes	No	Abnormal bleeding	Yes	No
Other_____			Other_____		

Patient Signature _____Date _____

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Please do not write in this space. Office use only.

Height _____ Weight _____Blood pressure _____ Pulse _____ Resp._____

MD Signature/initials _____Date_____