Eleanor J. Figuerres, D.O.

D.B.A. COMPREHENSIVE ORTHOPAEDICS, S.C.

Patient Acknowledgement & Record of Disclosures

I, _____ (Patient Name), _____ (Date of Birth) acknowledge that I have received the written Notice of Privacy Practices from Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.).

☐ 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: _____

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

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

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

Eleanor J. Figuerres, DO

D.B.A. Comprehensive Orthopaedics, S.C.

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS AND ACCEPT FINANCIAL RESPONSIBILITY

Please read carefully and sign below.

I, _____, request payment of authorized Medicare/Other Insurance Company benefits be made on my behalf to
(Patient Name)
Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.), for any services furnished to me. Regulations to Medicare assignment of benefits apply.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for any amount deemed by the insurance carrier to be beyond their "usual, customary and responsible" charges as well as for any amounts applied to deductible, insurance co-payments, or non covered services.

I hereby authorize Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.) to release to the Social Security Administration and Health Care financing Administration or its intermediaries, or insurance carriers, medical information needed for this or a related Medicare/Other Insurance Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be assigned to the Physician in charge of my care. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Insurance Coverage Agreement

_____ I have been informed that Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics S.C.) has verified my coverage with _____; however, if my coverage has been returned as inactive and/or terminated, I understand I will be held financially responsible for all services provided by Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics S.C.).

_____ I have been informed by Laura J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics S.C.) that they are a **non-participating provider** through _____. As a result, I understand I am financially responsible for any balance that my major medical insurance does not pay, including but not limited to co-payments and deductibles.

_____
Patient/Guardian Signature Date

Financial Policy

I have received and read the Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.) Financial Policy and agree with its terms and provisions. **I understand I am responsible for all Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.) charges regardless of my insurance status. In the event Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.) requires legal action to collect payment from me; I understand and agree that I will be responsible for all court costs and attorney fees.**

****IN THE EVENT 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, ELEANOR J. FIGUERRES, D.O. (D.B.A. COMPREHENSIVE ORTHOPAEDICS, S.C.) RESERVES THE RIGHT TO TERMINATE MY CARE FOR NON-COMPLIANCE AT ANY TIME****

Please sign below to verify that you have read all above information and agree to the terms.

_____
Patient/Guardian Signature **Date**

IF PATIENT IS A MINOR, PLEASE ALSO SIGN THE FOLLOWING SECTION:

I hereby authorize Eleanor J. Figuerres, D.O. or their designated clinicians to administer treatment as deemed necessary.

In divorce situations, the accompanying parent is responsible for the payment of charges, regardless of the divorce decree. Eleanor J. Figuerres, D.O. (D.B.A. Comprehensive Orthopaedics, S.C.) is not a party to your divorce and if payment issues exist they must be resolved between parents.

_____
Patient/Guardian Signature **Date**

Dr. Eleanor Figuerres

Welcome to the Practice! Please fill out this Medical History Form For New Patients

Name:_____
Date:_____
Age:_____ Date of Birth:_____
Referred to this practice by:_____/How did you hear about us:_____
Primary Care Physician:_____

Reason for Visit:

_____
_____
_____

Date and Place of Last Pap Smear:_____
Date and Place of Last Mammogram:_____

Past Gynecologic History:

Gynecologic Illness	Yes	Date	Gynecologic Illness	Yes	Date
Pelvic Inflammatory Disease			Fertility Issues		
Ovarian Cysts			Sexually Transmitted Diseases		
Uterine Fibroids			Abnormal Pap/ HPV Infection		
Endometriosis			DES Exposure		
Breast Disease			Polycystic Ovarian Disease		
Chronic Pelvic Pain/Vulvar Pain			Other		

Menstrual History:

Age at First Menses:	Date of Last Menses:
Usual Interval Between Periods	Usual # of Days Bleeding
Cramping with Periods	Heavy Bleeding: Yes or No
Bleeding Between Periods	Need for Pain Medications

Current Method of Contraception:_____
Gardasil Vaccination Dates: 1)_____ 2)_____ 3)_____

Obstetrical History:

Dr. Eleanor Figuerres

Year	Type of Delivery	Birth Weight	Complications

Past Medical History:

Past Medical History	Yes	Date	Past Medical History	Yes	Date
Asthma			Stroke		
Heart Disease			Bleeding/Clotting Disorders		
Mitral Valve Prolapse			Hepatitis		
Diabetes			HIV Infection		
High Blood Pressure			Anemia		
High Cholesterol			Depression		
Thyroid Abnormalities			Other Psychological History		
Epilepsy			Gastrointestinal Issues		
Eating Disorders			Kidney Disease		
Rheumatic Fever			Bone Density		
Tuberculosis			Colonoscopy		
Osteoporosis			Other		
Arthritis					
Lupus					

Past Surgical History (Including Non-Gynecologic Procedures):

Year	Procedure	Reason for Procedure

Dr. Eleanor Figuerres

Medications: (Include Prescription, Over-the-counter and Vitamin/Herbal Supplementations as well as dosages)

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____

Continue on back if needed.

Allergies: (Please type of reaction):_____

Social History:

Smoker? Yes No Quit	How many packs per day?_____ How many years?_____
# of alcoholic drinks per week?	Recreational Drug use?
Exercise regularly?	Occupation?

Family History

	Age	Relationship		Age	Relationship
Breast Cancer			Osteoporosis		
Colon Cancer			Prostate Cancer		
Ovarian Cancer			Pancreatic Cancer		
Uterine Cancer			Heart Attack/Disease		
Clotting/Bleeding Problems			High Blood Pressure		
Diabetes			Thyroid Disease		
Melanoma			Other		

Dr. Eleanor Figuerres

FOR PHYSICIAN USE ONLY:

NOTES:

AGE:

HEIGHT:

BP:

LMP:

UA:

HCG: