

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ Middle Initial: _____

If minor, Parent's Name & Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____

SSN: _____ Driver's License Number & State: _____

Home Telephone #: _____ Cell phone #: _____

Work Telephone #: _____ Email: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: White Black or African American Asian American Indian or Alaska Native

Native Hawaiian or other Pacific Islander Other Race

Preferred Language: English Other, please specify _____

Is this a result of a Motor Vehicle Accident? _____ **Work Injury?** _____

Primary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Secondary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Family Physician Name & Telephone #: _____

Emergency Contact's Name: _____ Telephone #: _____

How were you referred to our office? _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED TO BE SENT DIRECTLY TO ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, PA. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY, AND/OR MY PERSONAL ATTORNEY, _____ CONCERNING MY TREATMENT, AND THE RELEASE OF MY MEDICAL RECORDS TO ANY PHYSICIAN OR FACILITY TO WHOM I AM REFERRED.

PLEASE NOTE:

ALL CHARGES ARE PAYABLE AT THE TIME OF SERVICE. CHARGES FOR PROFESSIONAL SERVICES ARE THE RESPONSIBILITY OF THE PATIENT REGARDLESS OF INSURANCE COVERAGE.

AN ADMINISTRATIVE FEE OF \$20.00 WILL BE CHARGED FOR ALL RETURNED CHECKS.

SIGNATURE: _____ **DATE:** _____

5/17/11

MEDICAL HISTORY FORM

Name: _____ Today's Date: _____

SS#: _____ Date of Birth: _____

Family Physician Name & Telephone#: _____

Pharmacy Name & Telephone #: _____

What part of the body are you being seen for today? _____

Current Problem is the result of a:

Car Accident Work Accident Other _____ Date of Injury: _____

Medication	Dose	Reason for Medication	Side Effects

Do you have any allergies to any medications? Yes No

If yes, list and describe all that apply _____

Do you have an allergy to Latex? Yes No

Do you have an allergy to contrast dye or iodine? Yes No

Are all immunizations up to date: Yes No If no, which immunizations are due? _____

Are you Pregnant? Yes No

Are you Nursing? Yes No

Review of Systems None

Are you currently having or have you had problems with your:

- | | |
|--|--|
| <p>Eyes <input type="checkbox"/> Describe if not listed _____</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Vision loss</p> <p>Ears, Nose, Throat <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Trouble swallowing</p> <p>Respiratory, Lungs <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Shortness of breath</p> <p>Digestion <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Heartburn, ulcers</p> <p><input type="checkbox"/> Nausea, Vomiting</p> <p><input type="checkbox"/> Blood in stool</p> <p>Urinary <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Kidney problems</p> <p>Lymphatic <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Leg swelling</p> <p>Endocrine <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Heat or cold intolerance</p> <p>Weight <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Loss of appetite</p> | <p>Hematic, Blood <input type="checkbox"/> Describe if not listed _____</p> <p><input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Anemia</p> <p>Cardiovascular <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Palpitations</p> <p>Neurologic <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Balance problems</p> <p><input type="checkbox"/> Numbness/tingling</p> <p>Psychologic <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Drug/Alcohol addiction</p> <p><input type="checkbox"/> Sleep disorder</p> <p>Skin <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Frequent rashes</p> <p><input type="checkbox"/> Skin ulcers</p> <p><input type="checkbox"/> Lumps</p> <p>Vascular <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Claudication</p> |
|--|--|

MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

Past Medical History None

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Heart Attack/CAD | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pulmonary Emboli/Blood clot | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Degenerative Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Skin rashes/Psoriasis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer, specify type and treatment _____ | | |

Past Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes
 Have any problems with anesthesia? No Yes, describe: _____

Family History

Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfathers (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Do your parents, siblings, or grandparents have any of the following? Please check all that apply
 Bleeding disorders Diabetes Heart disease Stroke
 High blood pressure Rheumatoid Arthritis Osteoporosis Problems with anesthesia
 Cancer, specify type _____ Genetic disorder, specify type _____

Social History

Employed Unemployed Retired Disabled Student
 Single Married Divorced Separated Widowed
 Children? No Yes # _____
 Do you live alone? No Yes
 Exercise? Daily Weekly Monthly Rarely Never
 What type of exercise? _____
 History of substance abuse? No Yes What? _____
 Smoke currently? No Yes _____ packs per day for _____ years Never smoked
 Quit Smoking? This year >1 year >5 years >10 years
 Previously smoked _____ packs per day for _____ years
 Drink alcohol how many drinks per week _____ daily 1-2x/week 1-2x/month 1-2x/year

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____ Pg. 2



ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

ORTHOPAEDIC SURGEONS

Anthony J. Costa, MD
Steven P. Friedel, MD
Edmund R. Kappy, MD, FACS
Steven P. Lissner, MD

Daniel J. Mulholland, MD
Bernard P. Murphy, MD, FACS
Arthur H. Phair, MD
Keith M. Rinkus, MD

PHYSICAL MEDICINE & REHABILITATION

Randall L. Braddom, MD
Glenn M. Forman, MD
Michael A. Romello, MD

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

Middletown Office

80 Oak Hill Road
Red Bank, New Jersey 07701
Phone 732-741-2313 / Fax 732-741-7154

Marlboro Office

Kimer Professional Park - Building 3
25 Kimer Drive - Suite 105
Morganville, New Jersey 07751
Phone 732-617-9111 / Fax 732-617-5959

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of TPO. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in the notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Administrator. **We will not retaliate against you for filing a complaint.**

This notice is effective on April 14, 2003.



ORTHOPAEDIC, SPORTS MEDICINE AND REHABILITATION CENTER, P.A.

ORTHOPAEDIC SURGEONS

PHYSICAL MEDICINE & REHABILITATION

Anthony J. Costa, MD
Steven P. Friedel, MD
Edmund R. Kappy, MD, FACS
Steven P. Lisser, MD

Daniel J. Mulholland, MD
Bernard P. Murphy, MD, FACS
Arthur H. Phair, MD
Keith M. Rinkus, MD

Randall L. Braddom, MD
Glenn M. Forman, MD
Michael A. Romello, MD

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Practice's Notice of HIPPA Privacy: I have received a copy of the Notice of HIPPA Privacy for the Orthopaedic, Sports Medicine and Rehabilitation Center, PA.

Name of Patient Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

Home Telephone Number:

- OK to leave message with detailed information
Leave message with call back numbers only

Written Communication:

- OK to mail to my home address
OK to mail to my work/office address
OK to email to my email address

Work Telephone Number:

- OK to leave message with detailed information
Leave message with call back numbers only

Fax Communication:

- OK to fax to this number

B. I designate the following person listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: Last four digits of his/her SS Number (required):
Print Name: Last four digits of his/her SS Number (required):
Print Name: Last four digits of his/her SS Number (required):

C. The following person(s) are not authorized to receive my patient health information:

Print Name: Print Name:

III. The Privacy Notice generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided above will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Healthcare Operations may be permitted without prior consent.

Name of Patient Signature of Patient/Parent/Guardian Date

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FINANCIAL POLICY AND INSURANCE AUTHORIZATION

I authorize Orthopaedic, Sports Medicine and Rehabilitation Center, PA (“OSMRC”) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, or to any other insurance company for which I or my dependents or insurance beneficiaries is/are covered insureds, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare and/or other third-party insurance company benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to OSMRC. If my insurance carrier will not assign benefits to OSMRC, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan.

We are providers for some insurance plans and we will bill your insurance company directly. Most plans require co-payments and/or deductibles and co-insurance that are due at the time of service.

If we are not a participating provider with your insurance plan, or you do not have insurance, payment is expected in full at the time of service.

If your visit is a results of a work injury or motor vehicle accident, you must provide us with the following information prior to your visit: insurance carrier, claim number, adjuster’s full name and phone number, and date of accident. If your visit is not authorized by this insurance carrier, you will be fully responsible for services rendered.

I understand that I am responsible for all deductible, co-payment, co-insurance and/or charges for all non-covered services. It is customary to pay for services when rendered, unless other arrangements have been made. Acceptable forms of payment are cash, check, Visa, MasterCard, Discover, or American Express. There is a \$20 administration fee for any returned check. In the event I fail to pay for services rendered, when payment is due, my account will be turned over to collection.

Please feel free to contact our Billing Office if you have any questions. We are happy to answer your questions or to provide additional information.

I understand and acknowledge the financial policy and insurance authorization terms stated above.

Patient’s Name _____

Date _____

Signature _____

(Patient/Parent/Guardian)

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