

CORE ORTHOPEDICS & SPORTS MEDICINE

PATIENT ASSESSMENT

PLEASE PRINT USING BLACK OR BLUE PEN ONLY.

Patient's Legal Name: _____	(Last)	(First)	(M.I.)
Patient's Age: _____ Years	Date of Birth: ____ / ____ / ____	Height: (Ft) ____ (In) ____	Weight: _____
This form is being completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:			
Who is your Medical Doctor or Primary Care Physician? Name: _____ Address: _____ City: _____ State _____ Zip _____ Phone: (____) _____		Who referred you to Core? <input type="checkbox"/> Friend <input type="checkbox"/> E.R./Hosp. <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Doctor _____ <input type="checkbox"/> Other _____	
Pharmacy Name: _____		Pharmacy Phone: (____) _____	

HISTORY OF PRESENT ILLNESS (HPI)

Where is your pain located? _____ RIGHT LEFT
(Example: wrist, ankle, low back)

Which is your dominant hand? RIGHT LEFT

Approximate **date** of the onset of the present problem: _____

How did **this** problem occur? _____

Any previous problems to **this** area? No Yes If yes, describe: _____

1. Who have you seen for **this** problem? Not Previously Seen Family Physician
 Emergency Room _____ (Hospital) Other _____

2. Check off all past tests or treatments for **this** problem: X-ray Splint Medication Physical Therapy
 MRI Surgery Other _____

3. Intensity of pain (circle one): **None** 1 2 3 4 5 6 7 8 9 10 **Severe**

4. My pain is: Intermittent Constant

5. When do symptoms occur? _____
(example: after exercise, after long walks, after sitting for long periods of time, etc.)

6. Type of pain: Burning Aching Stabbing Sharp
 Shooting Deep Other _____

7. Does the pain radiate? No Yes To where? _____

MEDICAL HISTORY

	NO	YES		NO	YES		NO	YES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Use	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bladder control problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>						

Any other medical problems not listed? _____

PAST SURGICAL / HOSPITALIZATION HISTORY

Year	Hospital/Location	Reason

MEDICATION HISTORY

Please include prescription drugs, vitamins and drugs you buy over the counter.

Medication	Dose/Strength	When do you take it?	Reason you take the medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES - List any allergies you have and what type of allergic reaction you experience.

NO ALLERGIES

1. Allergy:	Reaction:
2. Allergy:	Reaction:
3. Allergy:	Reaction:
4. Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction:

SOCIAL HISTORY

Do you smoke? NO YES Packs/Day _____ Years _____
 Do you drink alcohol? NO YES Drinks/Day _____ Years _____
 Do you take a special diet? NO YES Describe: _____
 Marital Status: Married Single Widowed Divorced Separated **Do you live alone?** NO YES
 Home Environment: Apartment Private house Elevator Outside Steps Inside Stairs
 Were you independent in your activities of daily living prior to your injury? NO YES If no, please describe: _____

FAMILY HISTORY: (Please list any medical problems in your relatives.)

Father: _____ Mother: _____ Siblings: _____
 Others: _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY):

Are you currently pregnant? YES NO No. of Children: _____ No. of Pregnancies: _____ No. of Deliveries: _____

REVIEW OF SYSTEMS (ROS)

Please indicate which, if any, of the following problems you have by circling YES or NO:

Constitutional Good general health Yes No Recent weight change Yes No Night sweats, fevers Yes No Fatigue Yes No			Ears / Nose / Mouth / Throat Hearing loss or ringing Yes No Sinus problems Yes No Nose bleeds Yes No Sore throat/voice change Yes No			Eyes Wear glasses/contacts Yes No Blurred/double vision Yes No Eye disease or injury Yes No		
Cardiovascular Chest pain Yes No Palpitations Yes No Heart trouble Yes No Swelling hands/feet Yes No			Respiratory Shortness of breath Yes No Cough Yes No Coughing up blood Yes No			Gastrointestinal Nausea/vomiting Yes No Abdominal pain Yes No Rectal bleeding Yes No Bowel problems Yes No		
Musculoskeletal Muscle pain or cramps Yes No Stiffness/swelling joints Yes No Joint pain Yes No Trouble walking Yes No			Neurological Frequent headaches Yes No Paralysis or tremors Yes No Numbness/tingling Yes No			Integumentary (Skin / Breast) Change in hair or nails Yes No Rashes or itching Yes No Breast lump Yes No Breast pain or discharge Yes No		
Endocrine Excessive thirst/urination Yes No Hormone problem Yes No			Hematologic / Lymphatic Bruise easily Yes No Slow to heal Yes No Enlarged glands Yes No			Allergic / Immunologic Food allergies Yes No Aspirin allergies Yes No Antibiotic allergies Yes No		
Genitourinary - Male Only Blood in urine Yes No Kidney stones Yes No Sexual problems Yes No Testicle pain Yes No			Genitourinary - Female Only Blood in urine Yes No Kidney stones Yes No Sexual problems Yes No Menstrual problems Yes No			Psychiatric Insomnia Yes No Confusion/memory loss Yes No Anxiety Yes No Substance Abuse Yes No		

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY :

I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature: _____ Date: _____

Patient's or Responsible Party's Signature: _____ Date: _____

CERTIFICATION BY PHYSICIAN:

I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who submitted the information in the Patient's behalf.

Physician's Signature: _____ Date: _____ Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____ Physician's Signature: _____ Date: _____

Temp _____ Pulse _____ Reg Irreg. Resp. _____

CORE ORTHOPEDICS & SPORTS MEDICINE

Payment Policy

Our Thanks

The physicians and staff of Core Orthopedics and Sports Medicine thank you for choosing our practice to care for your health care needs. We are deeply committed to ensuring that your treatment is successful. Your clear understanding of our payment policy is important to our professional relationship.

Please note: It is not our policy to provide the patient a copy of the day's charges/bill on the day of service. However, we will provide a receipt for any payment made that day. If a copy of the charges for that days visit is necessary, please ask for one to be mailed. For your convenience, we accept cash, check, Visa, Mastercard.

Insurance Information

As a courtesy for you, our billing office will file a claim with all requested documentation to your insurance provider on your behalf. We will provide this service for both your primary insurance and, when applicable, for your secondary insurance provider. In order to process your claim for you, we **must** have the necessary information which includes the insurance carrier's name, address and phone number. We also need the subscriber's name, birth date, employer, group number and identification number. Fortunately, most of this information is provided on the insurance card itself.

Insurance Coverage Can Be Confusing

We understand that many patients find insurance coverage and financial responsibility issues complex and confusing. The following graph was developed in response to this need and has helped to answer many patient's questions. If you have any questions about our policies, our staff will be happy to assist you.

Payment Responsibility for Office Visits and Services

IF YOU HAVE...	YOU ARE RESPONSIBLE FOR...	CORE ORTHOPEDICS & SPORTS MEDICINE
Medicare	<ul style="list-style-type: none"> • Paying your deductible, co-pay, and for any services that are not covered by your plan, at the time of your appointment. 	<ul style="list-style-type: none"> • File for Medicare reimbursement on your behalf. • File secondary insurance on your behalf when applicable.
Private Insurance Plans	<ul style="list-style-type: none"> • Paying your deductible and/or co-pay at the time of service. 	<ul style="list-style-type: none"> • File your primary insurance claim as a courtesy to you. • File secondary insurance on your behalf when applicable.
HMO and PPO Coverage	<ul style="list-style-type: none"> • Providing all required referrals. • Paying your deductible and/or co-pay at time of service. 	<ul style="list-style-type: none"> • File claims on your behalf.
Self Pay, Uninsured, Liability, Auto Claims or Other 3rd Party Claims	<ul style="list-style-type: none"> • Payment-in-full at the time of each appointment. 	<ul style="list-style-type: none"> • Provide you a copy of your itemized billing statement for reimbursement or tax purposes.
Work-related injuries (DEPARTMENT OF LABOR CLAIMS ONLY)	<ul style="list-style-type: none"> • Providing claim information. • Payment of any charges for disputed or denied claims. 	<ul style="list-style-type: none"> • File claims on your behalf. • Provide necessary information to the Department of Labor. • Provide information to rehabilitation consultant.

Commercial Insurance Policy

For your convenience, we will file your commercial insurance claims. If your insurance carrier does not pay within 45 days, you will be responsible for the payment of your incurred charges. Since the cost of billing and collections is expensive, your prompt payment for service will help to contain overhead costs and limit our need to increase fees.

Medicare Policy

As a courtesy to our patients, Core accepts Medicare assignment. We will file your claims to Medicare for you, and hold billing until after Medicare has responded to the claim. Medicare will pay 80% of their allowable, and the patient, or their secondary insurance, is responsible for the remaining 20%. Naturally, your Medicare deductible must be met first.

If you supply our office with the correct billing information, we will also file with your secondary insurance carrier on a one-time basis. If your secondary insurance carrier does not pay within 60 days, you will then be responsible for the balance.

HMO and PPO Coverage

We do our best to contact all of our doctors with as many HMO and PPO insurance carriers as possible in an effort to accommodate all of our patients. However, there may be some that we are not contracted with at this time. Also there may be an occasion when one of our doctors refers you to another doctor or service (for example, MRI, Therapy, Bone Mineral Density Scanning or Pain Management Services) within our network. In this event, it is the **responsibility of the patient to confirm** with their HMO or PPO the doctors or services's participation in their insurance plan. Our office will bill these insurance carriers directly. You are responsible for any co-pay or co-payment at the time of service. You will be billed for any deductible or co-insurance balances.

If your insurance company requires a referral from a primary care physician, it will be necessary for you to bring a referral form with you covering each day of service. Most HMO's and some POS's require that we have a referral slip or they will not pay for the services provided. If you do not have a valid referral form or referral authorization number, your appointment will be rescheduled.

Worker's Compensation

Worker's compensation claims are not covered by your regular insurance. Our office requires written verification by your employer of a Worker's Compensation claim. This information must be received by our office before your visit. Please include the following: name, address and phone number of employer; name, address and phone number of Workers' Compensation Carrier; claim number and name of contact person. If this requirement is not completed, your appointment will be rescheduled.

Self Pay

Patients who do not have health care insurance are advised that they need to be prepared to pay up to \$200.00 towards their initial visit. A bill will be sent if there is a remaining balance. The balance should be paid within thirty days. For future visits, payment will be expected at the time of service.

Minor Patients

Patients under 18 years of age cannot be treated unless accompanied by a parent or another adult who has written authorization. The individual who accompanies the child and contracts for treatment will be responsible for payment in full as outlined in the Commercial Insurance/Self Pay Policy section. The adult who accompanies the minor is responsible to have all the appropriate information for treatment and payment.

Usual and Customary

Occasionally, a non-contracted insurance company will make the decision that our standard fees exceed their interpretation of 'usual and customary'. We have taken great efforts to base our fees in accordance with our doctor's expertise in their specialty, as well as the quality of care provided at our facility or in the hospital. If your insurance company should arbitrarily decide that our fees exceed "usual and customary", we will review our charges to be sure that they are appropriate and fairly reflect the service provided. Any unpaid portion, such as co-payments, deductible, non-covered items, and fees that exceed "usual and customary", we will review our charges to be sure that they are appropriate and fairly reflect the service provided. Any unpaid portion, such as co-payments, deductible, non-covered items, and fees that exceed "usual customary" interpretations are the responsibility of the patient.

Rebilling Fees

Core reserves the right to charge a rebilling fee of \$10.00 for accounts with an outstanding balance of 60 days or more.

Medical Records Fee

The cost for medical record copies, including X-ray film duplication, disability forms, etc. are examples of services **not** covered by insurance carriers. The patient is responsible for these fees in the event a request is made for these services.

How May I Pay For Medical Services?

We do accept cash, checks, Visa, MasterCard, Discover and American Express. In the event that your bank returns payment made by a personal check, a service fee of \$25.00 will be billed to your account.

CORE ORTHOPEDICS & SPORTS MEDICINE

REGISTRATION INFORMATION

I. INJURY / EMERGENCY CONTACT	
Part of Body Affected: _____	Date of Injury: _____
Who referred you to this office? _____	Who is your primary Dr.? _____
Address: _____	Phone: (____) _____
In case of Emergency who should be notified? _____	
Phone: (____) _____	Relationship: _____
II. PATIENT INFORMATION	
Legal Name: _____	Social Security No.: _____
Age: _____	Date of Birth: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
Address: _____	City: _____ State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____ Work Phone: _____
Driver's License No.: _____	Employer's/School Name: _____
Employer's/School Address _____	City: _____ State: _____ Zip: _____
III. GUARANTOR INFORMATION (If different from Patient)	
Legal Name: _____	Social Security No.: _____
Age: _____	Date of Birth: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Patient: _____
Address: _____	City: _____ State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____ Work Phone: _____
Driver's License No.: _____	Employer's Name: _____
Employer's Address: _____	City: _____ State: _____ Zip: _____
IV. PRIMARY INSURANCE INFORMATION	
Name of Ins. Co.: _____	Policy ID No.: _____
Group No.: _____	Phone No.: _____ Co-Payment: \$ _____ Referral Needed: <input type="checkbox"/> YES <input type="checkbox"/> NO
If different than patient, fill in below:	
Name of Policyholder: _____	Date of Birth: _____
Address: _____	City: _____ State: _____ Zip: _____
Social Security No.: _____	Employer: _____
V. SECONDARY INSURANCE INFORMATION	
Name of Ins. Co.: _____	Policy ID No.: _____
Group No.: _____	Phone No.: _____ Co-Payment: \$ _____ Referral Needed: <input type="checkbox"/> YES <input type="checkbox"/> NO
If different than patient, fill in below:	
Name of Policyholder: _____	Date of Birth: _____
Address: _____	City: _____ State: _____ Zip: _____
Social Security No.: _____	Employer: _____
VI. WORKER'S COMPENSATION OR LEGAL/ACCIDENT (If applicable)	
Name of Carrier: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone No.: _____	Claim No.: _____ Name of Adjuster: _____
Employer at Time of Accident: _____	Phone No.: _____
Name of Attorney: _____	Phone No.: _____
Verification of W/C: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date Made: _____ by: _____
ASSIGNMENT AND RELEASE	
I certify that I, and/or my dependent, have insurance coverage and assign directly to Core Orthopedics & Sports Medicine and its affiliates, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. This consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.	
Signature of Patient, Parent, Guardian or Personal Representative _____	Please print name of Patient, Parent, Guardian or Personal Representative _____
_____ Date _____	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian/POA
	Account No. _____ (For Office Use Only)

CORE ORTHOPEDICS & SPORTS MEDICINE

UNIVERSAL CONSENT FORM

PATIENT NAME: _____

CONSENT FOR TREATMENT

It is my wish to be treated by Core Orthopedics & Sports Medicine. I give permission for Core physicians, physician assistants, chiropractic physicians and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication, examinations, X-rays, tests or minor procedures that my Core physician determines to be necessary. I understand my Core physician will explain to me the nature of my condition, his/her recommended treatment and any associated risks involved. I also understand that he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

I have been given an explanation and a copy of Core "HIPAA Notice of Privacy Practices" and understand that I may call Core Privacy Official if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by State and Federal laws. Core may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices.

I understand that except as regulated by law, my medical record information will not be released should I refuse to sign this form.

Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize payment to Core Orthopedics & Sports Medicine and its physicians (who agree to accept this assignment) and assign all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers Compensation, or any other health plans under which I may be entitled to reimbursement. I understand that I am financially responsible to Core for charges not covered by my insurance and this assignment.

In consideration of medical services provided by Core to the above-identified patient, I agree to pay to Core all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/or reasonable attorney fees. I hereby authorize my attorney to pay Core any outstanding balances due immediately upon receipt of any Workers' Compensation and/or Third Party Insurance Case settlement.

DISCLOSURE OF OWNERSHIP

Core is required to inform you that several of our physicians are investors in Core Orthopedics & Sports Medicine.

Medicare Certification and Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payor as it applies to my Medicare health care insurance.

X _____
Initials of Guarantor / Patient

Sharing Of Medical Information: I hereby authorize Core to share my registration, medical history, billing, insurance information, etc. within its own network. The sharing of information should avoid having you complete an identical form a second time and allow our staff to pre-approve tests or procedures more quickly, thereby expediting your medical care when utilizing other services within Core.

X _____
Initials of Guarantor / Patient

I have read and understand the above information and agree to its content:

Signature (Patient/Parent/Legal Guardian)

Date

Signature of Guarantor (if other than above)

Date

Signature of Witness:

Date