Montgomery Orthopaedics

Consent to Use and Disclosure of Health Care Information for Treatment, Payment or Healthcare Operations

I understand that as part of my care, Montgomery Orthopaedics originates and maintains health records describing my health history, including, but not limited to the following:

- symptoms
- examination
- test results
- diagnoses
- treatment
- plans for future care and treatment

This information is used for the planning and management of your care as well as a means of communicating among all healthcare professionals involved in your care. This information is also used by your insurance company for payment of services rendered. I have read the ***NOTICE OF INFORMATION PRACTICES*** that goes into much more detail of how information is used and disclosed and understand that I have the following rights:

- You have a right to request limits on the way we use or disclose your health information.

- You must make the request in writing to our Office and tell us what information you want to limit and to whom you want the limits to apply.

- Montgomery Orthopaedics is not required to agree to the restriction.

- You have the right to request how we provide confidential communications to you.
  For example, we may communicate your test results to you by mail or by telephone.

- You may ask us to share information with you in a certain way or in a certain place.
  For example, you may ask us to send information to your work address instead of your home address; you may also request that we call you at work instead of at home.
  You must make this request in writing.

- You do not have to explain the reason for your request. We are required to follow your request, if it is reasonable.

You may revoke your authorization to use or disclose protected health information at any time; the revocation must be in writing. The revocation will not affect uses or disclosures that have already been made.

I request the following restrictions to the use of my protected health information:

Signature (patient or legal guardian) Date

Montgomery Orthopaedics

ORTHOPAEDIC SURGERY
SPINE SURGERY
ARTHROSCOPIC SURGERY
HAND SURGERY
JOINT REPLACEMENT
FRACTURE CARE
PHYSICAL THERAPY

Clifford Hinkes, MD, FAAOS

Philip L. Schneider, MD, FAAOS

Daniel Pereles, MD, FAAOS
Certificate of Added Qualification in Sports Medicine

Antoni B. Goral, MD, FAAOS

Harrison Solomon, MD, FAAOS
Certificate of Added Qualification in Hand Surgery

Karen Frangione, PA-C

Efrain Hernandez
Administrator

10400 Connecticut Avenue Kensington, MD 20895
301-949-8100 FAX 301-962-7450
www.montgomeryorthopaedics.com

Fax Transmittal

To: Montgomery Orthopaedics **Fax: (301) 962 - 7450**

Date:

From:

Re: Patient Registration Forms

Number of Pages:

Montgomery Orthopaedics

Your Visit Today is with: Dr. Hinkes Dr. Schneider Dr. Pereles Dr. Goral Dr. Solomon Dr. Keeling K. Frangione

Patient Information

Acct #_____ Date: _____

First Name	Middle	Last	Race	Ethnicity

Street Address	City	State	Zip

Birth date	Age	Sex	Home Phone	Work Phone	Date of Onset or Injury	Social Security #

Employer	Employer Address

Next of Kin/Emergency Contact Name	Relationship to Patient	Phone #

Injured on the job? Y N	Work Comp Claim #	Adjuster Name	Adjuster Tel#	

Auto Accident? Y N	Auto Claim #	**Allergies**

Individual Responsible for Payment

First Name	Middle	Last	

Street Address	City	State	Zip

Home Phone	Work Phone	Employer	Social Security #

Employer Address

Primary Insurance Company

Name	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Date of Birth	Relationship to Insured

Secondary Insurance Company

Name	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Date of Birth	Relationship to Insured

Patient Authorization – Assignment of Benefits & Consent to Telephone Contact

I hereby authorize **Montgomery Orthopaedics, PA** to apply for benefits on my behalf for services rendered by any provider within the group, and request that payments are made directly to **Montgomery Orthopaedics, PA**. from my insurance carrier to include Medicare/Medicaid benefits, I also authorize the release of information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third-party carrier as necessary to secure payment of any benefits due me. I understand that I am responsible for all charges, co-payments and items and or services not covered under my insurance plan regardless of insurance status as well as any associated interest on unpaid balances and costs for collection should such action become necessary. **I understand that if Montgomery Orthopaedics does not participate with my insurance** carrier they will courtesy bill them; however I am fully responsible for all unpaid balances, co-pays, fees and deductibles as well as any associated interest on unpaid balances and costs for collection should such action become necessary. I further understand that I will be charged $25.00 any returned check. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

We may place reminder calls 1 or 2 days before your appointment. We will disclose the appointment date & time, physician name and requests for referrals, x-rays, MRI and patient balances due, if applicable. Please check how you want us to contact you:

☐ **Home** ☐ **Work (Tel#)_____** ☐ **You may speak to anyone who answers the phone**

☐ **You may only speak to:_____Relationship: _____**

☐ **Leave a message in my answering machine** ☐ ***DO NOT CALL***

Signature _____ Date _____

Today's Date _____

PLEASE PRINT CLEARLY

Name:	Date of birth:	Age:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Pregnant? ☐ Y ☐ N

What are your main symptoms:	What makes the problem worse?
	What makes the problem better?

Date of Onset of problem/injury:	What happened?

What treatment Have you received?

Have you Had this before? ☐ Yes ☐ No

How much pain are you experiencing?

1 2 3 4 5 6 7 8 9 10

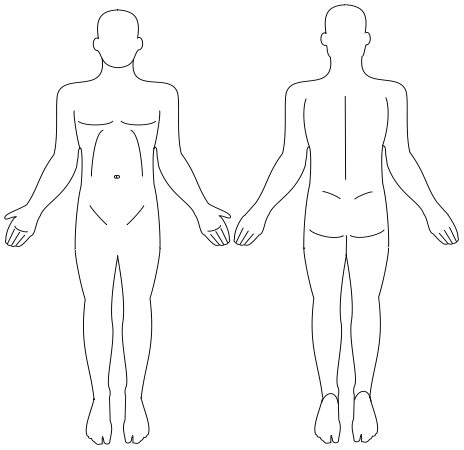
0= No Pain 10=Excruciating Pain

Is your present condition the result of an accident? ☐ Yes No ☐

If you answered yes, what was the nature of the accident?

Automobile | Bicycle | Home | Motorcycle | Sports | Work | Other:

Please circle the area (s) where you are having problems



Referring doctor's name: Telephone:

Primary Care physician's name: Telephone:

Please list other injuries/broken bones:

Previous surgeries

Surgeries	Approx Date

List current medications & dose:

Check all conditions/illnesses that apply:

☐ Cancer ☐ Gout ☐ Lung disease ☐ Bleeding problems ☐ Asthma ☐ Kidney disease ☐ High Cholesterol ☐ Gastrointestinal ☐ Arthritis ☐ Diabetes ☐ HIV positive ☐ High blood pressure ☐ Heart disease

Other: _____

List all allergies

Family History	Age	Diseases
Father		
Mother		
Brother		
Sister		
Spouse		
Children		

LMP:

Alcohol use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Use of Tobacco: Packs per day >

Use of Drugs: ☐ Never (if Yes, give type/frequency:

Reviewed by: ☐ Dr. Hinkes ☐ Dr. Schneider ☐ Dr. Pereles ☐ Dr. Goral ☐ Dr. Solomon ☐ K. Frangione

Montgomery Orthopaedics

• MUSCULOSKELETAL	No	Yes
Joint pain		
Joint stiffness or swelling		
Weakness of muscles or joints		
Muscle pain or cramps		
Back pain		
Cold extremities		
Difficulty in walking		

• INTEGUMENTARY (skin. breast)	No	Yes
Rash or itching		
Change in skin color		
Change in hair or nails		
Varicose veins		
Breast pain		
Breast lump		
Breast discharge		

• NEUROLOGICAL	No	Yes
Frequent or recurring headaches		
Light headed or dizzy		
Convulsions or seizures		
Numbness or tingling sensations		
Tremors		
Paralysis		
Stroke		
Head injury		

• PSYCHIATRIC	No	Yes
Memory loss or confusion		
Nervousness		
Depression		
Insomnia		

• ENDOCRINE	No	Yes
Glandular or hormone problem		
Thyroid disease		
Diabetes		
Excessive thirst or urination		
Heat or cold intolerance		
Skin becoming dryer		
Change in hat or glove size		

• HEMATOLOGIC/LYMPHATIC	No	Yes
Slow to heal after cuts		
Bleeding or bruising tendency		
Anemia		
Phlebitis		
Past transfusion		
Enlarged glands		

• ALLERGIC/IMMUNOLOGIC	No	Yes
History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics		
Morphine, Demerol, or other narcotics		
Novocain or other anesthetics		
Aspirin or other pain remedies		
Tetanus antitoxin or other serums		
Iodine, methiolate or other antiseptic		

• CONSTITUTIONAL SYMPTOMS	No	Yes
Good general health lately		
Recent weight change		
Fever		
Fatigue		
Headaches		

• EYES	No	Yes
Eye disease or injury		
Wear glasses/contact lens		
Blurred or double vision		
Glaucoma		

• EARS - NOSE-MOUTH & THROAT	No	Yes
Hearing loss or ringing		
Earaches or drainage		
Chronic sinus problem or rhinitis		
Nose Bleeds		
Mouth sores		
Bleeding gums		
Bad breath or bad taste		
Sore throat or voice change		
Swollen glands in neck		

• CARDIOVASCULAR	No	Yes
Heart trouble		
Chest pain or angina pectoris		
Palpitation		
Shortness of breath with walking or lying flat		
Swelling of feet, ankles or hands		

• RESPIRATORY	No	Yes
Chronic or frequent coughs		
Spitting up blood		
Shortness of breath		
Asthma or wheezing		

• GASTROINTESTINAL	No	Yes
Loss of appetite		
Change in bowel movements		
Nausea or vomiting		
Frequent diarrhea		
Painful bowel movements or constipation		
Rectal bleeding or blood in stool		
Abdominal pain or heartburn		
Peptic ulcer (stomach or duodenal)		

• GENITOURINARY	No	Yes
Frequent urination		
Burning or painful urination		
Blood in urine		
Change in force of strain when urinating		
Incontinence or dribbling		
Kidney stones		
Sexual difficulty		
Male - testicle pain		
Female - pain with periods		
Female - irregular periods		
Female - vaginal discharge		

Female - # pregnancies	# miscarriages
Female - date of last pap smear	

Montgomery Orthopaedics

Date of Service _____

Patient Name _____

Insurance Co. _____

Account No. _____

Provider: ☐ CH ☐ PS ☐ DP ☐ AG ☐ HS ☐ KF ☐ DG ☐ LA ☐ BM

SERVICES RENDERED WITHOUT A REFERRAL

Your insurance company requires you to have a referral for each visit to our office. At this time we have not received authorization for today's visit. If you wish to keep your appointment we request you sign the the following statement:

I hereby waive all insurance benefits for today's visit and understand that I will assume personal responsibility for payment of all services rendered by Montgomery Orthopaedics since I am presently unable to provide the necessary referral as required by my insurance company. My insurance company will not be billed for today's services under any circumstances. I agree to pay $150.00 (one hundred and fifty dollars) as a minimum **deposit** for today's visit. In the event that charges for today's visit exceed the $150.00 deposit, I agree to pay the balance today.

Deposit Amount: _____

Credit Card ☐

Check # _____

Date _____

Patient Signature _____

(Parent, guardian if minor or authorized agent if so designated)

Date _____

Witness _____

Montgomery Orthopaedics

BC/BS
MDIPA
Alliance
Optimum Choice
HMO/PPO

Your insurance carrier has placed coverage restrictions on certain supplies and will not pay for:

- Cervical Collars
- Immobilizers
- Slings
- Splints
- UNNA Boot

Depending on your plan, covered supplies are subjected to a co-payment up to 50% of the charge; therefore we ask that you make payment of 50% of the charges for any supplies you receive today.

BENEFICIARY AGREEMENT

I have been notified by Montgomery Orthopaedics that my insurance may deny payment for orthopaedic supplies and or appliances prescribed. If my insurance carrier denies payment for any supplies and or appliances not listed, I agree to be personally responsible for the payment. I agree to pay 75% of the charges for supplies and or appliances not listed above and 100% for the items listed above at the time of the visit today. Should my insurance pay for more than 75% of the supplies or appliance, Montgomery Orthopaedics will process the payment in accordance with contacted agreements with your insurance carrier. Any amount remaining after applicable deductibles, co-payments, co-insurance and patient responsibility amounts will be refunded.

_____

Beneficiary or Guardian's Signature Date