

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:



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:

This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential or privileged, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient you are hereby notified that any dissemination, distribution or copying is strictly prohibited. If you received this message by error, please notify us immediately and destroy the message.

CONFIDENTIAL HEALTHCARE INFORMATION This message may contain protected health information that is of a sensitive and confidential nature. It is being sent to you with the authorization of the patient or under circumstances where authorization is not required. You are required to maintain this information in a secure and confidential manner and are prohibited from re-disclosing it without first obtaining the patient's consent or as otherwise permitted by law. Unauthorized re-disclosure may subject you to federal and state law penalties.

	Montgomery	Your Visit
A	Orthopaedics	

t Today is with: Dr. Hinkes

Dr. Hinkes Dr. Schneider Dr. Solomon Dr. Keeling Dr. Pereles K. Frangione Dr. Goral

Patient Information				Acct	#	C	Date:			
First Name	Middl	е	Last		Race	Et	hnicity			
Street Address	i		Cit	у			State		Zip	
Birth date	Age	Sex	Home Pl	none	Work Phon	e	Date of Onset of	or Injury		Social Security #
Employer					Empl	oyer Address				
Next of Kin/Emergency Contact Name					Relat	ionship to Patient		Phon	e #	
Injured on th	e job?	Work Corr	p Claim #	Adjuster	Name	Adjus	ter Tel#			
Y	N									
Auto Accident? Auto Claim # Aller		Allergie	S				I			
Y	N									

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 I mill **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#)	\square 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

Name:				LEASE PRINT CLE	
	Date of birth:	Age:	Single Divorc	Married Separated	Pregnant?
What are your main symptoms:	birtin.	What makes the p			
		What makes the p	roblem better?		
Date of Onset of	Vhat				
problem/injury: h	appened?				
What treatment Have you received?					
Have you Had this before?	ls your p	present condition	the result of an ac	cident? 🗌 Yes	No
⊡Yes ⊡No			was the nature of t		
How much pain are you experiencing	J? Auton	nobile) Bicyc	e Home	Other:	
1 2 3 4 5 6 7 8	9 10 Motor	cycle Sports	s Work		
0= No Pain 10=Excru	uciating	Referring doctor's	name:	Telep	phone:
Pain		mary Care		Teler	phone:
Please circle the area (s) where you are hav		/sician's name:			
	>				
	Plea	ase list other injuri	es/broken bones:		
)				
2λ					
		evious surgeries			
	Sur	geries		Ap	prox Date
List current medications & dose:					
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Montgomery Orthopaedics	, PA - Patient Intake Form rev	2/05
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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	INO	ies
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	INU	163
Bleeding or bruising tendency		
Anemia		
Phlebitis		
Past transfusion		
Enlarged glands		Yes
ALLERGIC/IMM UNOLOGIC	No	
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Date of Service	Account No.
Patient Name	Provider: CH PS DP AG
Insurance Co.	
	Пвм

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	



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