Updated 2/6/2020

Date: _____

ELLIS & BADENHAUSEN ORTHOPAEDICS, PSC

PATIENT INFORMATION

Patient Name (First, Last) | **Sex** M_____ F_____ | **Marital Status** S_____M_____W_____ D_____Sep_____ | **Date of Birth**

Address | **City** | **State** | **Zip**

Home Phone | **Cell Phone** | **Work Phone** | **Social Security Number**

Race/Ethnicity ___Caucasian ___Black/African American ___ Asian ___Native American ___Asian Pacific American ___Pacific Islander ___Native Hawaiian ___Subcontinent Asian American ___American Indian or Alaskan Native ___Latino/Hispanic ___Other Race ___ More than One Race ___Unknown ___I Do Not Wish To Provide This Information

Patient Email Address | **Family Physician** | **Referring Physician**

Date of the Injury | **Are You Currently Employed?** YES _____ NO_____ | **If Employed, Patient Employer**

Is this a workers' compensation claim? YES _____ NO_____ | **Is this injury a result of an automobile accident?** YES _____ NO_____

Emergency Contact | **Phone Number** | **Relation to the Patient**

Pharmacy Name | **Pharmacy Address** | **or** | **Pharmacy Phone Number**

PRIMARY INSURANCE INFORMATION

Primary Insurance Company | **Policy ID & Group Number** | **Effective Date**

Policy Holder's Name (If Policy Holder is different then patient) | **Policy Holder's Social Security Number** | **Policy Holder's Date of Birth** | **Policy Holder's Employer**

Subscriber of the Insurance ____Patient ___Spouse ___Father ___Mother ___Other | **Subscriber Address (If different than the patient)**

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company | **Policy ID & Group Number** | **Effective Date**

Policy Holder's Name (If Policy Holder is different then patient) | **Policy Holder's Social Security Number** | **Policy Holder's Date of Birth** | **Policy Holder's Employer**

***Guarantor Name (If patient is a minor)** | **Guarantor Address** | **Guarantor Phone Number**

*Per office policy, Guarantor is person presenting with the patient at time of service

CONSENT TO TREATMENT/BENEFIT ASSIGNMENT/FINANCIAL RESPONSIBILITY

(SIGNATURE REQUIRED)

I hereby give my consent for treatment to ELLIS & BADENHAUSEN ORTHOPAEDICS, P.S.C.
I assign the benefits allowed by my insurance company to be paid to their office instead of myself. I have been notified by Ellis & Badenhausen Orthopaedics, P.S.C. that I am responsible for payment, should any of my charges be denied due to lack of a referral. In addition, I understand that I am responsible for any Durable Medical Equipment not covered by any insurance company. I agree to be personally and fully responsible for payment of any amounts unpaid by my insurance company.

_____ _____

PATIENT NAME DATE

_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

ELLIS AND BADENHAUSEN ORTHOPAEDICS, P.S.C.
FINANCIAL POLICY

INSURANCE
We will bill your insurance company as a courtesy to you. If they do not respond to our claim within sixty (60) days, you are responsible for the entire amount of the bill. You are responsible for any amounts not paid by your insurance company, including amounts applied to deductible, non-covered charges, co-pays, and co-insurance. You will receive a monthly statement once the insurance company has paid or denied your claim OR if the insurance company has not responded within sixty (60) days of the filing of the claim.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY; WE ARE NOT A PARTY TO THAT CONTRACT.

PAYMENT PLANS
Payment plans are available by contacting the Bookkeeping Office at (502) 587-7269. We accept Visa, American Express, Mastercard, and Discover and can take your payments over the phone.

MEDICARE
We accept assignment on Medicare payments. However, Medicare will only pay for services that it determines to be "reasonable and necessary," Section 862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, it will deny payment for that service.

WORKER'S COMPENSATION
We will make every effort to verify coverage on your worker's compensation claim before your visit. If, for some reason, payment is denied or claims are unpaid by the worker's compensation carrier, you are responsible for the bill. If your worker's compensation is denied and you have health insurance, we will be glad to file that for you under the conditions stated above.

REFERRALS
You are responsible for seeing that you have a referral for each visit, service, and supply. We will be glad to help you in this process but, should payment be denied for a lack of referral, you are responsible for the balance.

EXPRESS PRIOR CONSENT TO WIRELESS TELEPHONE CONTACT
By signing below, you consent and agree to receive calls and text messages at the wireless telephone number set forth below, including, but not restricted to, communications regarding billing and payment for goods and services, which could result in charges to you. **Such calls and text messages include, but are not restricted to, calls using an automatic telephone dialing system, or an artificial or prerecorded voice, or by any other form of electronic communication now known or later discovered,** from us, our affiliates, contractors, servicers, clinical providers, attorneys, or their agents, including collection agencies. **You are not required to sign this Consent or to agree to enter into this Consent as a condition of purchasing property, goods, or services from the Practice.**

_____ _____
PATIENT SIGNATURE PRINT NAME

_____
PATIENT HOME ADDRESS

_____ _____
CELL PHONE NUMBER DATE

R. JOHN ELLIS, JR. M.D.
LAWRENCE A. SCHAPER, M.D.
MARK G. SMITH, M.D.
G. JEFFREY POPHAM, M.D.
AKBAR NAWAB, M.D.
MICHAEL L. SALAMON, M.D.
MATTHEW R. PRICE, M.D.
DANIEL E. RUEFF, M.D.
SEAN M. GRIFFIN, M.D.
ERIN M. GISH, PA-C
KELSI JO BARNES, PA-C

ELLIS & BADENHAUSEN
ORTHOPAEDICS, PSC

HIPAA Acknowledgment Form

I acknowledge the Practice has provided me the opportunity to have a copy of its Notice of Privacy Practices. The copy provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

R. JOHN ELLIS, JR. M.D.
LAWRENCE A. SCHAPER, M.D.
MARK G. SMITH, M.D.
G. JEFFREY POPHAM, M.D.
AKBAR NAWAB, M.D.
MICHAEL L. SALAMON, M.D.
MATTHEW R. PRICE, M.D.
DANIEL E. RUEFF, M.D.
SEAN M. GRIFFIN, M.D.
ERIN M. GISH, PA-C
KELSI JO BARNES, PA-C

ELLIS & BADENHAUSEN
ORTHOPAEDICS, PSC

INFORMATION RELEASE FORM

HIPAA Privacy Rules provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. Ellis and Badenahusen Orthopaedics require direct designation by the patient to release personal protected information.

I, _____, HEREBY GIVE ELLIS AND BADENHAUSEN ORTHOPAEDICS PERMISSION TO RELEASE OR DISCUSS ONE OR MORE OF THE FOLLOWING ISSUSES WITH:

Name	OFFICE	LABS	X-RAYS	CONSULTS	HOSPITAL	INS. /BILLING	ALL

EXCEPTIONS: (DO NOT RELEASE THIS INFORMATION)

_____

_____

_____ _____

PRINT PATIENT NAME Patient Date of Birth

_____ _____

PATIENT SIGNATURE DATE

Today's Date_____

ELLIS & BADENHAUSEN ORTHOPAEDICS, PSC

Patient Data Sheet

Patient Name _____ Date of Birth _____

Occupation_____ Marital Status: Single / Married / Divorced / Widowed/ Separated

Family Doctor _____ Height_____Weight_____

Who referred you to us?_____

Local Pharmacy/Phone #/Address _____

Reason for today's visit_____ Date of Injury _____

On a scale of 0 to 10, where 0 is no pain, and 10 is the worst pain you have ever experienced, how would you rate your pain today? (circle) 0----1----2----3----4----5----6----7----8----9----10

Are you pregnant or could you be pregnant? Y / N **Dominant Hand**: Left / Right

Drug Allergies	**Reaction**	**Drug Allergies**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any **metals**? Y / N
Which metals? _____
Reaction: _____

Do you have any allergies to **foods**? Y / N
Which foods?_____
Reaction: _____

Do you have a **latex** allergy? Y / N
Reaction: _____

Current Medications	**Dosage**	**Times per Day**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all Previous Surgeries	**Date of Surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? Y / N If yes, how many packs per day? _____ Are you a former smoker? Y / N Quit Date:_____

Alcohol Use? Y / N How much/how often do you use alcohol? _____

Drug Use? Y / N Type/Frequency? _____

PLEASE CONTINUE ON THE BACK OF THIS PAGE

Do you have a <u>Family History</u> of any of the following? - Please select all that apply.

____ Arthritis
____ Bleeding Problems
____ Cancer
____ Diabetes
____ Heart Disease
____ Stroke
____ Hypertension
____ Bone Problems
____ Lung Disease
____ Kidney Disease
____ Other (Please explain)_____
____ Unknown

Patient's <u>Medical History</u> - Please select all that apply to you.

____ ADD/ADHD
____ Asthma
____ Anxiety
____ Aneurysm
____ Cancer
____ Cardiac Problems
____ Cataracts
____ Cholesterol Problems
____ Compartment Syndrome
____ Congestive Heart Failure
____ COPD
____ Coronary Artery Disease
____ Crohn's Disease
____ Poliomyelitis
____ PTSD
____ Depression
____ Diabetes
____ Esophageal Reflux
____ Emphysema
____ Epilepsy/Recurrent Seizures
____ Rheumatoid Arthritis
____ Gout
____ Hearing Loss
____ Heart Disease
____ Hepatitis (Type A / B / C)
____ HIV Infection
____ Hypertension (High Blood Pressure)
____ Lupus
____ Menopause
____ Migraines
____ Multiple Sclerosis
____ Osteoarthritis
____ Osteopenia
____ Osteoporosis
____ Deep Vein Thrombosis/Blood Clot
____ Pulmonary Embolism
____ Prostate Disorder
____ Prior Heart Attack
____ Psoriasis
____ Renal Disorders
____ Pacemaker
____ Stroke
____ Syncope (Fainting)
____ Thromboembolic Disease
____ Thrombophlebitis
____ Thyroid Disorders
____ Transient Ischemic Attack
____ Tuberculosis
____ MRSA
____ Staph Infection
____ Wear Eyeglasses/Contacts
____ Ulcers
____ Fibromyalgia
____ Anemia
____ Fracture (Body Part)_____
_____
_____
____ Seasonal Allergies
____ Scoliosis
____ Sleep Apnea
____ Other (Please List) _____
_____

Are you <u>currently experiencing</u> any of the following symptoms?

____ Weight Change
____ Chills
____ Fever
____ Night Sweats
____ Unusual Fatigue
____ Headache
____ Eye symptoms
____ Neck pain
____ Neck stiffness
____ Lump/swelling in Neck
____ Coughing up Blood
____ Wheezing
____ Shortness of Breath
____ Fast Heart Rate
____ Heart Palpitations
____ Chest Pain
____ Heartburn
____ Nausea
____ Vomiting
____ Abdominal Pain

____ Diarrhea
____ Difficulty Swallowing
____ Difficult/Painful Urination
____ Blood in Urine
____ Increased Urinary Frequency
____ Vertigo
____ Dizziness
____ Enlarged Lymph Nodes
____ Excessive Thirst
____ Excessive Sweating
____ Easy Bleeding
____ Easy Bruising
____ Skin Lesions
____ Rashes
____ Pruritus
(Severe itching)

____ Numbness
____ Tingling
____ Seizure
____ Fainting
____ Weakness
____ Anxiety
____ Depression
____ Hallucinations
____ Other Psychological Problems (Please list) _____
_____

Physician Reviewed _____ Date _____