Name:

Chart:

Date: DOB

PATIENT REGISTRATION

Patient's Name:	Patient's Birthdate:	Age:	Sex:
Street Address PO Box:	City:	State:	Zip Code:

****Please provide your complete physical address and P.O. Box if applicable.**

Patient's SSN:	Marital Status:	Preferred Language: (Circle one) English Spanish _____ Declined

Race (Circle one) African American / Black Caucasian / White American Indian Native Hawaiian Asian Declined

Ethnicity (Circle one) Hispanic Non-Hispanic Declined | Do you text? ☐ Yes ☐ No

Other than appointment reminders; how do you prefer to be contacted? ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email ☐ Mail ☐ Fax _____

Phone: Home	Phone: Cell	Phone: Work
Employer:	Employer Address:	
Occupation:		May we contact you at work? YES ☐ NO ☐
Email Address:		

Family Physician:	City:	Phone:
Referring Physician:	City:	Phone:
Pharmacy:	City:	Phone:
Parent / Guardian Name (if under 18):	Relationship:	Phone:

The following person/persons have authorization to my personal health information, including appointments and test results and are also my emergency contacts:

1 Name:	Relationship to Patient:	Phone:
2 Name:	Relationship to Patient:	Phone:

How did you hear about us? ☐ Physician NP / PA ☐ Friend Relative ☐ ER ☐ Newpaper Radio ☐ Yellow Pages ☐ Internet ☐ Billboard

INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARD(S) TO THE RECEPTIONIST

Primary Insurance:		Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's SSN:	Relationship to patient:
Policy Holder's Address (if different from patient):		
Secondary Insurance:		Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's SSN:	Relationship to patient:
Policy Holder's Address (if different from patient):		

Is This A Work Injury or Liability Accident? Y ☐ N ☐	Date of Injury or Accident:	Have you filed OR do you intend to file a Work Comp / Liability claim? Y ☐ N ☐

IF YES TO THE ABOVE, PLEASE NOTIFY THE RECEPTIONIST UPON ARRIVAL

****Physical and Occupational Therapy, MRI and DME products can be obtained at a facility of my choice.**

Name:

Chart:

Date: DOB:

Initials	
	Authorization for medical treatment: As a patient of the Orthopaedic Center, I do hereby voluntarily consent to such medical care and treatment encompassing standard diagnostic procedures, outpatient therapy, and the performance of any other procedures by the Orthopaedic Center, as their judgment deems medically advisable. I understand that if I have any questions regarding my examination I may request an explanation at any time. (Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.)

Initials	
	Release of Information: I understand that the Orthopaedic Center of Southern Illinois will make every effort to treat my medical information as confidential; however, I realize information must be shared with providers and/or individuals involved in my care or on the payment of my care. I understand this will include information found in my medical record, to include alcohol, drug abuse, communicable disease, including HIV status, and/or psychiatric diagnosis. I agree to the release of information in my medical record, and to the actual medical record documents, to the extent necessary for the following purposes: to those responsible for collecting and those responsible for the payment of my care. This may include a person, Medicare government agency, insurance company, health plan or employer sponsored group plan.

Initials	
	"No Show" Appointment Policy: A "No Show" is when a patient does not show up **or** does not call to cancel prior to the time of a scheduled appointment. ▪ All no shows will be documented in the patient's chart and the patient will be notified by letter of the missed appointment. If a 3rd no show should occur, the patient may be formally released from the office. ▪ When you are formally released from the office, the office will provide **only** emergency care for a period of 30 days.

Initials	
	Assignment of Benefits: In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by the Orthopaedic Center of Southern Illinois and all attending physicians, I hereby irrevocably transfer to said Orthopaedic Center of Southern Illinois and all attending physicians, all Medicare/Insurance benefits now due and payable to me and/or surgical services rendered by physicians for whom the Orthopaedic Center of Southern Illinois is authorized to charge and bill. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I will also pay all costs and expenses of collection, including reasonable attorney fees. I hereby authorize electronic billing for all of my claims.

A copy of this signature is as valid as the original and is in effect until I revoke it.

Signature - Relationship to Patient | Date of Birth | SSN | Date

Name:
Chart:
Date: DOB:

PATIENT FINANCIAL POLICY

To be signed electronically at your appointment. Please keep for your records.

As health care providers we are committed to providing the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is committed to providing outstanding customer service for all financial questions.

Identification Proper identification AND current insurance cards must be presented prior to service being rendered.

Marketplace (Obamacare) If your insurance policy is purchased through the Health Insurance Exchange Marketplace (Obamacare), we will verify that your premium has been paid on a basis as services are provided. We highly recommend that you pay your premium before the due date, and ONLINE. If you choose to mail your payment, it could delay processing for up to two weeks. If the premiums are not paid, the account will be placed in a self-pay status, at which time the self-pay financial policy will be followed.

Commercial Health Insurance

- **Co-Payments** - Insurance companies require that co-payments be paid at the time of service. We may notify your insurance company if you fail to pay your co-payments.
- **Co-Insurance / Deductibles** - As a courtesy, and if your insurance allows, we will research your insurance plan benefits. As determined by your insurance plan, prepayment for any unmet deductible and/or coinsurance amounts will be requested to be paid prior to services being rendered.
- **Non-Participating Insurance** - Orthopaedic Center of Southern Illinois (OCSI) does not contract with every insurance company. Patients are responsible for asking if OCSI is a participating provider with their insurance company. OCSI will bill non-participating insurances. Outstanding balances are the responsibility of the patient.
- **Tests and/or Procedures** - Prior to scheduling tests or procedures, you must meet with a Financial Counselor to determine your out of pocket expenses and required pre-payment.
- **Secondary Insurance** - As a courtesy OCSI will file to your secondary insurance carrier.

Medicare

- OCSI will submit claims to Medicare, however, we may request that you sign an ABN form for non-covered services.

Worker's Compensation

- **IF YOU HAVE ANY INTENTION OF FILING YOUR CLAIM AS WORKER'S COMP PLEASE DO SO PRIOR TO YOUR APPOINTMENT.**
- Patients shall supply Work Comp contact information prior to services being rendered.
- If the worker's compensation claim is pending at the Commission, we may remind you of your balance due. If you fail to provide us with appropriate claim information within 90 days, the balance will be your responsibility and full payment will be expected. Upon settlement, OCSI may resume collection efforts from the patient if the balance is not paid in full by worker's comp. Patients will be responsible for all services obtained and/or the remaining balance owed if work comp fails to pay.

Name:
Chart:
Date: DOB:

Medicaid

- If your plan requires a copay, $3.90 will be collected at check in. If you fail to pay this amount we have the right to notify your managed care plan.
- If you have applied for Medicaid but have not yet been accepted, payment is expected in full when services are rendered.

Motor Vehicle / Third Party Liability

- Patients shall be financially responsible for medical services related to motor vehicle accidents.
- Patients should supply liability contact information prior to services being rendered.
- If a third party insurance is involved, and there is no health insurance, the **Self Pay** policy will be followed.
- We do not bill attorneys for medical services, or wait for payment from a settlement. If the personal injury policy exhausts on the MVA insurance, we will bill the patient's regular medical insurance plan or the private party.
- All insurance benefits are to be directed to the Orthopaedic Center of Southern Illinois.
- By law, OCSI is required to bill any liability insurance first if you have Medicare, Medicaid or Tricare.

Self-Pay

- Self-pay accounts exist if patients have no insurance coverage.
- An estimated payment is required prior to your appointment. This payment must be received 1 week prior to your appointment. Any charges exceeding this amount is your responsibility and will be billed to you. A minimum payment will be expected prior to seeing the provider on each date of service. At the discretion of the provider, your appointments may be rescheduled pending your ability to pay for services.
- Payment for services must be paid prior to scheduling. Payment for office visits will be collected upon check in.

Minors of Divorced Parents and Child Custody Cases

- Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent listed as the Guarantor for the child will be financially responsible and any statements will be mailed directly to that parent.

Statements / Payments

- Statements are sent to patients on a monthly basis.
- Payment Methods: We accept all major credit cards, checks, money orders, and cash.
- Returned Check Fees: A fee of $25.00 will be charged for all returned checks.

Note: Balances in collections must be paid prior to further treatment. The collection agency and your health insurance company will be called to verify payment and current benefits prior to scheduling an appointment. If you have an outstanding balance with Costa Law Firm, OCSI's primary collection agency, a generous attempt must be made to pay on the bad debt. If you are without insurance, the self-pay policy listed above applies.

I hereby assign, to Orthopaedic Center of Southern Illinois, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments, co-insurance or deductibles.

To be electronically signed by the patient

Name:
Chart:
Date: DOB:

PATIENT TO FILL OUT TOP HALF OF PAGE

NEW COMPLAINT HISTORY FORM

Date: _____

Patient Name _____ DOB _____ Age _____ Sex: M F HT: _____ WT: _____

Appt requested by: _____ Primary Physician: _____

Allergies: _____ Dominant Hand: RT LT

Employer: _____ Type of Work _____ Work Status: _____

Chief Complaint: _____

On a scale of 0 - 10 (10 being the worst) how severe is your pain? _____ Does your pain wake you from sleep? Y N

❑ Pain is:
- ❑ Sharp
- ❑ Dull
- ❑ Throbbing
- ❑ Aching
- ❑ Stabbing
- ❑ Burning
- ❑ Constant
- ❑ Comes and goes (intermittent)

❑ Other Symptoms:
- ❑ Swelling
- ❑ Bruising
- ❑ Numbness / Tingling
- ❑ Popping / Grinding
- ❑ Weakness
- ❑ Locking / Catching
- ❑ Loss of control of bladder or bowel
- ❑ Giving Way / Instability
- ❑ Weight Loss / Gain
- ❑ Night Sweats

❑ What makes your symptoms worse?
- ❑ Standing
- ❑ Walking
- ❑ Lifting
- ❑ Exercise
- ❑ Twisting
- ❑ Bending
- ❑ Lying in Bed
- ❑ Riding in car
- ❑ Driving a car
- ❑ Overhead Reaching
- ❑ Squatting
- ❑ Kneeling
- ❑ Stairs
- ❑ Sitting
- ❑ Coughing
- ❑ Sneezing
- ❑ Activities
- ❑ Pushing
- ❑ Pulling

❑ What makes your symptoms better?
- ❑ Rest
- ❑ Ice
- ❑ Heat
- ❑ Elevation
- ❑ Medication
- ❑ Reposition

Other _____

DO NOT WRITE BELOW THIS LINE ----- OFFICE USE ONLY

How did your problem start?

❑ Injury Date
- ❑ Accident _____
- ❑ Work Related _____
- ❑ Sports Related _____
- ❑ Auto Accident _____

❑ No Injury
- ❑ Gradual Onset
  How long? _____
- ❑ Sudden Onset

BP _____

Location:
Posterior Anterior Medial Lateral

History of Complaint: _____

Head On Broad Side Rear Ended Estimated Speed _____

Restrained? Y N Extent of Damage: _____ Vehicle Totaled Y N

X-RAYS:	Date: _____	Location:	_____
MRI:	Date: _____	Location:	_____
NCV / EMG:	Date: _____	Location:	_____
Other: _____	Date: _____	Location:	_____

Previous Treatment:

(What helped vs what did not?) _____

Previous Injury: _____

Physical Therapy: _____

Injections: _____

Other: _____

Previous Medications: _____

_____

RT LT

Grip Strength _____

Key Pinch _____

2 Point Discrimination

RT LT

1st _____

2nd _____

3rd _____

4th _____

5th _____

Name:
Chart:
Date: DOB:

Patient Name: _____ DOB: _____ Date: _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Do you have or have you had any of the following?

	YES	NO		YES	NO
Heart Disease			COPD		
Malignant Hyperthermia			Asthma		
Stroke			Emphysema		
Aneurysm			Tuberculosis		
Seizure disorder			Ulcers		
High BP			Reflux Disease		
Abnormal Rhythm			Thyroid Disease		
Blood Transfusion			Liver Disease		
Anemia			Kidney Disease		
Blood Clots			Renal Failure / Dialysis		
Bleeding Disorder			Urinary Problems		
Hepatitis			Sleep Apnea		
HIV/Aids			Gout		
Depression			Numbness/Tingling		
Alcoholism			Osteoarthritis		
Bipolar			Low Back Pain		
Schizophrenia			Osteoporosis		
Skin Condition			Glaucoma		
IBS / Diverticulitis			Implants		
Shortness of Breath			Pacemaker		
Appetite	↑	↓	Dementia/ Alzheimers		
Hernia			MRSA		
Diabetes			Cancer		
Insulin Depend			Location		
❑ Type 1			Year		
❑ Type 2			Other:		

Do you wear / use any of the following?

❑ Glasses ❑ Contacts ❑ Hearing Device
❑ Walker / Cane ❑ Dentures

List all past surgeries with dates: _____

ADVANCED DIRECTIVES: ❑ Y ❑ N If yes, provide copy

Pharmacy Name and Address: _____

List all medications you are currently taking.

FAMILY MEDICAL HISTORY

Do any of these problems run in your family?

	YES	NO		YES	NO
Heart Disease			Asthma		
Stroke			Gout		
Bleeding Disorder			Diabetes		
Aneurysm			Kidney Disease		
Arthritis			Thyroid Disease		
Malignant			Mental Illness		
Hyperthermia			Alcoholism		
Osteoporosis					

Cancer—if yes what type? _____

SOCIAL HISTORY

What are your current living arrangements?

❑ Single ❑ Widowed ❑ Skilled care facility
❑ Married ❑ Lives at home ❑ Lives with parent (s)
❑ Divorced ❑ Nursing home

Are you currently pregnant? ❑ Y ❑ N
# of times pregnant: _____ # of living children: _____
Do you use tobacco products? ❑ Y ❑ N
❑ cigarettes PPD / #yrs _____ / _____
❑ e-cigarettes
❑ chewing tobacco ❑ illegal drug(s) use
Do you drink? ❑ Y ❑ N How much? _____
Recreational Activities: _____

_____
Patient / Guardian Signature Date

_____
Evaluator Signature Date

_____
Provider Signature Date