Orthopedic Intake

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: Male or Female

What are we seeing you for? _____

_____

Have you had Flu vaccine? ❑ Yes ❑ No Date_____ Pneumonia vaccine? ❑ Yes ❑ No Date_____

List of Past Surgeries: _____

_____

_____

List all Prescriptions and over the counter Medications: _____

_____

_____

Is this work related? ❑ Yes ❑ No MVA ❑ Yes ❑ No

Social History:

Most Recent Occupation: _____

Do you live alone? _____

Do you use tobacco? _____

If yes, packs per day _____

Do you drink alcohol? _____

If yes, drinks per day _____

Family History:

Cancer Heart Attack
Diabetes Stroke

Review of Systems: In the past 30 days have you experienced any of the following:

Fever/Chills	Yes	No
Chest Pains	Yes	No
Dizziness	Yes	No
Swelling in the legs	Yes	No
Bruising	Yes	No
Bleeding	Yes	No
Joint Pain/Stiffness	Yes	No
Muscle Pain/Stiffness	Yes	No
Seizure	Yes	No

You are __ R handed __ L handed

Allergies:

None _____

Adhesive Tape	Yes	No
Codeine	Yes	No
Latex	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Dye/Iodine	Yes	No

Other:

_____

_____

_____

_____

_____

Past Medical History:

Anemia
Asthma
Coronary Heart Disease
Depression
Diabetes
Type 1___ Type 2___
DVT
Gerd/Reflux
GI Bleed
Hepatitis A, B, C
High Blood Pressure
HIV
Hypothyroidism
Kidney Disease
Liver Disease
Neurological Disorder
Osteoarthritis
Osteoporosis
Pulmonary Embolism
Rheumatoid Arthritis
Seizures Disorder
Stroke

Patient Profile

Please bring your insurance cards and a list of medications to all appointments.

Physician: _____ Preferred Pharmacy/City: _____

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name:_____

Date of Birth: _____ Sex: M F Social Security Number: _____

Race: __African Amer./Black __Amer. Indian/Alaskan Native __Asian __Caucasian/White __Nat Hawaiian/Pacific Islander __Other

Ethnicity: __Hispanic or Latino __Not Hispanic or Latino __Declined Primary Language: _____

Marital Status: __ Single __ Married __ Widowed __ Divorced Other: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work #: (___) _____ Cell #: (___) _____

E-mail Address: _____ Preferred Method of Contact:__Phone __Mail __Patient Portal

Were you referred to our practice by another physician: __Yes __No If so, Name: _____

Primary Care Physician: _____ Emergency Contact Phone #: _____

Insurance: **MUST PRESENT CARD AT TIME OF VISIT OR PAYMENT WILL BE REQUIRED IN FULL**

Primary Insurance: _____ Policyholder/Name on Card: _____

Secondary Insurance: _____ Policyholder: _____

Patient's Employer (if not applicable, insert "n/a"): _____

Spouse or Parent's Name: _____ Date of Birth: ____ / ____ / _____

Spouse or Parent's Employer: _____ Social Security Number: _____

ASSIGNMENTS OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverages, in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid for by my insurance.

Signature of Patient or Legal Guardian: _____ Date: _____

Dickson Orthopaedics, PA
DBA Jonesboro Orthopaedics and Sports Medicine

Lifetime Authorization Statement
Assignment of Benefits for Direct Payment

PATIENT NAME: _____ **MR#:**_____

Dickson Orthopaedics, PA is pleased that you have selected this group to provide for your medical needs.

Please review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. Please sign where indicated and return it to the receptionist. If you disapprove, we certainly respect your right of refusal. However, please be aware that, without your legal signature, we cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, we will have no alternative but to require that you be responsbile for the cost of services rendered in full. (See reverse side for Refusal to Sign Lifetime Authorization Statement). Should you refuse this option, we have no other choice than to cancel your appointment.
Thank you in advance for your cooperation.

LIFETIME AUTHORIZATION STATEMENT/ASSIGNMENT FOR DIRECT PAYMENT

I hereby instruct and direct my current insurance carrier to pay by check made payable to:

Dickson Orthopaedics, PA
1416 E. Matthews, Suite 200
Jonesboro, AR 72401

the medical, surgical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to **Dickson Orthopaedics, PA** and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment, including applicable co-payments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to **Dickson Orthopaedics, PA**. A photocopy of this assignment shall be considered as effective and as valid as the original. I understand that **Dickson Orthopaedics, PA** does accept assignment for Medicare and payments will be directed to **Dickson Orthopaedics, PA**. Should my account be referred for collection procedures, I will also pay reasonable attorney's fees and collection expenses.

INSURANCE INFORMATION

Dickson Orthopaedics, PA attempts to verify benefit information with insurance companies prior to each patient's visit. However, insurers do not guarantee the accuracy of the data they provide. Therefore, the information **Dickson Orthopaedics, PA** provides the patient is only our best estimate based on the data provided by the payer. Patients are urged to contact their insurance carrier directly to verify that copays, coinsurance, deductibles, and covered services. Regardless of **Dickson Orthopaedics, PA's** estimates, the patient's responsibility will be based on the payer's final adjudication. Payments of any kind may be applied to any open charges on the patient's account.

CONSENT FOR TREATMENT

I authorize **Dickson Orthopaedics, PA** to provide treatment as necessary for which I am, or my minor child is being seen. This includes, but is not necessarily limited to, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury or illness.

RELEASE OF MEDICAL RECORDS

I hereby authorize **Dickson Orthopaedics, PA** to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, health care service plans, workers' compensation carriers, adjusters or attorneys, to the extent necessary to obtain reimbursement; Also to the patient's personal physician, referring physicians, or primary care physician. I am aware that any/all information contained within my medical records/chart is Property of **Dickson Orthopaedics, PA**.

Lifetime Authorization Statement
Assignment of Benefits for Direct Payment

PATIENT NAME: _____ **MR#:**_____

ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED DUE TO AN ACCIDENT-RELATED TO AUTO, WORK COMP OR OTHER

If I receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, aware by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to **Dickson Orthopaedics, PA** to the extent of any outstanding amounts then owed by me to **Dickson Orthopaedics, PA** for medical services before any other fees, costs or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by **Dickson Orthopaedics, PA** shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, aware, jury verdict or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to **Dickson Orthopaedics, PA** shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties.

I understand that I remain personally responsible for the payment of all fees owed by me to **Dickson Orthopaedics, PA** and that notwithstanding this Assignment and lien, **Dickson Orthopaedics, PA** is not required to look to any other person or entity for payment.

I have given authorization to **Dickson Orthopaedics, PA** to forward a copy of this document to my attorney. This assignment and lien shall be effective regardless of whether it is countersigned by any such attorney.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS All THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

_____	_____	_____
Signature of Patient/Responsible Party	Signature of Witness	Date

REFUSAL TO SIGN

I, the above named, have been presented with the Lifetime Authorization Statement/Assignment of Benefits for Direct Payment Form and have refused to sign. In doing so, I am assuming full responsibility for all charges incurred during my evaluation and treatment at **Dickson Orthopaedics, PA**. I understand that these charges are due in full at the time of service. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

_____	_____	_____
Signature of Patient/Responsible Party	Signature of Witness	Date

Dickson Orthopaedics, PA
dba Jonesboro Orthopaedics and Sports Medicine

Patient Authorization for Use and Disclosure of Protected Health Information

Please PRINT below any family, friends, etc. that you would like to be able to give information to. These names will be added as contacts in our computer system and should anyone call requesting information, the list will be referenced and information will not be disclosed if the name is not indicated in the computer from your list below. The person that is listed as your emergency contact DOES NOT automatically get added to this list. If you would like them listed, please list them below.

NAME	RELATIONSHIP	CONTACT NUMBER

Signature _____ **Date** _____
(Patient, Parent or Legal Guardian)