New Patient Intake And History Form

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Decatur Orthopedic Center

Today's Date: _____ ☐ **Male** ☐ **Female** **SSN#** _____
(Needed for Insurance/Work Comp)

Name: _____ **Date of Birth:** _____

Address: _____

Home Phone #: _____ **Cell Phone #:** _____ **Work Phone #** _____

Email: _____ **Place of Employment:** _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Family/Primary Care Doctor: _____ **Living Situation:** ☐ Home ☐ Nursing Home ☐ Other

Are you currently under the care of a Cardiologist? ☐ No ☐ Yes – Cardiologist's Name: _____

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

Reason For Coming To The Doctor Today:

Reason for Today's Visit: _____

Worker's Comp? ☐ Yes ☐ No Date of Injury: _____

Timing/Onset: When did symptoms first occur? _____

Duration: Frequency of symptoms? _____

Characterized as/Severity: Describe the severity of the symptoms/pain. _____

Associated Signs and Symptoms: Are there any other symptoms associated with your problem?

_____

_____

Modifying Factors: What makes the condition better and/or worse? _____

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

☐ AIDS	☐ Clotting disorder	☐ Emphysema	☐ Hist. of MRSA infection	☐ Pregnancy
☐ Anemia	☐ COPD	☐ GERD	☐ HIV	☐ Pulmonary embolus
☐ Anticoagulant use	☐ Depression	☐ Heart attack	☐ Kidney Disease	☐ Seizure
☐ Anxiety	☐ Diabetes (Type 1)	☐ Heart disease	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Diabetes (Type 2)	☐ Hepatitis	☐ Neuropathy	☐ Thyroid disease
☐ Cancer	☐ DVT	☐ High blood pressure	☐ Pacemaker	☐ Ulcer

☐ Other: _____

Past Surgical History:

Please list any procedure(s) you have had in the past. Then write the year, reason, and hospital on the line to the right of it. ☐ None

_____

_____

_____

Medication History:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

Condition	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Anemia						
Anxiety Disorder						
Asthma						
Cancer						
Clotting Disorder						
COPD						
Depression						
Diabetes Mellitus						
DVT						
Emphysema						
GERD						
Heart Attack						
Heart Disease						
Hepatitis						
High Blood Pressure						
History of MRSA						
HIV-positive						
Kidney Disease						
Liver Disease						
Neuropathy						
Pulmonary Embolus						
Seizure Disorder						
Stroke						
Other						

Allergy History:

☐ None ☐ NKDA (No Known Drug Allergies)

☐ Betadine
☐ Cephalosporins (Keflex)
☐ Cipro
☐ Clindamycin
☐ Codeine/Codeine Derivatives
☐ Hydrocodone
☐ Iodinated Contrast Media
☐ Latex
☐ Levaquin
☐ Morphine Derivatives
☐ NSAIDs / Anti-inflammatory Drugs
☐ Nickel
☐ Norco
☐ Penicillin
☐ Sulfa Drugs
☐ Tramadol
☐ Vancomycin
Other:

Social History:

Most recent primary occupation: _____

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No
If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No
If yes, please indicate what type of drug and how often: _____

Review Of Systems:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

General: ☐ Normal
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

Skin: ☐ Normal
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Ulcer
- ☐ Change in Wart/Mole
- ☐ Dryness

HEENT: ☐ Normal
- ☐ Blurred Vision
- ☐ Decreased Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Earache
- ☐ Ringing in the Ears
- ☐ Nose Bleed
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Toothache

Respiratory: ☐ Normal
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Difficulty Breathing

Breast: ☐ Normal
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge

Cardiovascular: ☐ Normal
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Dizziness

Gastrointestinal: ☐ Normal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Rectal Bleeding

Genitourinary: ☐ Normal
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinating at Night
- ☐ Incontinence
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Neurological: ☐ Normal
- ☐ Headaches
- ☐ Numbness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Tremor
- ☐ Unsteadiness

Endocrine/Glands: ☐ Normal
- ☐ Appetite Changes
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Hair Changes
- ☐ Sexual Dysfunction

Hematology: ☐ Normal
- ☐ Easy Bruising
- ☐ Gland Problems
- ☐ Anemia

Discrimination is Against the Law

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Decatur Orthopedic Center

Decatur Orthopedic Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Decatur Orthopedic Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Decatur Orthopedic Center:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Shelly Doyle.

If you believe that Decatur Orthopedic Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Shelly Doyle
104 Ashland Ave.
Mt. Zion, IL 62549
217-864-2665, 217-864-8042 (fax)
sdoyle@decaturothopediccenter.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Shelly Doyle is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for the Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

_____ _____

Signature of patient or responsible party Date

Financial Policy

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Decatur Orthopedic Center

The following statement is our Financial Policy. It is required that the patient and/or responsible party (hereinafter referred to as "you") read and sign this statement prior to any treatment. All patients and/or responsible parties must also complete and sign our Information and Insurance form prior to treatment.

Self Pay

A $200.00 payment is due prior to treatment from all uninsured new patients. If you are being seen for a follow-up visit, you will be required to pay $75.00 prior to your visit. Any additional balance due will be required at checkout on the day of your visit.

WE ACCEPT CASH, CHECKS, VISA, OR MASTERCARD.

Insurance

We participate with many insurance companies. We reserve the right to accept or deny assignment of insurance benefits. If we accept assignment of benefits, it is your responsibility to supply our office with a copy of your current insurance card. If we do not participate with your insurance company, then your insurance policy is a contract between only you and your insurance company. The balance on your account is your responsibility. In the event we do accept assignment of benefits, and your insurance company has not paid your account in full within 60 days, you will be expected to pay your balance. Please keep in mind that some, and perhaps all, of the services provided may be a non-covered service under your insurance plan and that payment for the service is your responsibility.

Regarding insurance plans where we are participating providers, all co-pays and deductibles are due at time of service.

Usual and Customary

Any reduction of payment or denial of payment by your insurance company due to "usual and customary rates" is your responsibility to pay. Our charges are based on the usual and customary rates for our area. They are not based on the determination of any insurance company.

Workers' Compensation

You must notify us prior to being seen by the physician if we are seeing you for a work-related injury. Your employer must complete and sign an "employer's worker's compensation claim acknowledgment" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number, and claim number if applicable). This information must be provided to us prior to treatment. If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. Decatur Orthopedic Center will not accept a delay in payment due to a worker's compensation dispute and/or litigation. We may accept assignment of your health insurance benefits.

Liability Injury

If you are being seen due to a liability injury, you must provide the following information for billing and verification of payment prior to treatment:

***Auto Accident:** If you were injured in **your** own car, you must provide us with the name and address of **your** auto insurance company, **your** agent/adjuster's name, telephone number, **your** claim number, and date of accident. If your injury occurred in someone else's car, we require **all of the above information** and the following: **their** name, the name and address of **their** auto insurance company, **their** agent/adjuster's name, telephone number, and **their** claim number. We do not bill 3rd party insurance.

***Slip and fall, etc:** If you were injured on residential property or in a residential dwelling, we require the following: **homeowner's** name, the name and address of **their** homeowner's insurance company, **their** agent/adjuster's name, telephone number, **their** claim number, and the date of the accident. If your injury occurred at a place of business, please provide basically the same information.

If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. Decatur Orthopedic Center will not accept a delay in payment due to settlement disputes and/or litigation. We may accept assignment of your health insurance benefits.

Minor Patients

The following parties are responsible for payment of the minor's account balance, the adult accompanying the minor, and the parents (or guardians of the minor). A minor that is not accompanied by an adult will be denied any **non-emergency** treatment unless charges for the treatment have been pre-authorized.

Assignment Of Benefits And Release Of Records

You do hereby assign to Decatur Orthopedic Center the medical benefits to which you or your dependents are entitled. You also authorize Decatur Orthopedic Center to furnish to your health insurance company all your patient information including, but not limited to, any and all medical records, notes, test results, x-ray reports, MRI reports, or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize Decatur Orthopedic Center to release any and all patient information and medical records necessary to collect this debt. Please refer to our Notice of Privacy Practices for information on how we protect your privacy rights.

No Show Appointments

If you are unable to keep your scheduled appointment, please be courteous by cancelling at least 24 hours in advance. Multiple no show appointments may result in you not being allowed to schedule future appointments with our physicians.

Form Fees

If you have forms that need to be completed by a physician or nurse, a fee will be charged to you. The fee is required to be paid in full prior to any form being completed. Examples of these forms are, but not limited to, disability forms, attending physician statement, and personal injury statements.

Finance Charges And Return Check Fees

You agree to pay a finance charge at the rate of 1 1/2% per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a $20.00 service charge on all return checks.

Collection Costs And Procedures

If my account becomes delinquent, I agree to pay all costs incurred including, but not limited to, all reasonable attorney's fees, filing fees, court costs, and collection agency contingency fees. I understand that a fee ranging from 40%-50% will be added to the total balance due. By signing this policy, you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and their attorneys in the collection of this debt. I also give the collection agency the right to contact me via telephone number, including cellular. In addition, I am giving the collection agency permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and/or employment information.

For your information, the healthcare professionals in this practice are financially integrated. If you are referred to a healthcare professional in this practice for imaging, occupational medicine, physical therapy services, or occupational therapy services, please note that you may request and receive a referral for these services independent of this practice.

By signing below, you affirm that you have read and understood our Financial Policy, and that you agree to its contents.

_____ _____

Signature of patient or responsible party Date