Date: ____________________

(Use Black Ink Only)

PATIENT INFORMATION

Full Name: (Last)________________________________(First)_______________________(Middle)_________________

Maiden Name:_______________________ Male________Female________ Birth Date: _______/______/________

Social Security #: ____________________________________Status:Single____Married____Divorced____Widowed___

Race: White____Black or African American____Hispanic____Asian____Other___________Language:_______________

Mailing Address: ____

City:____State:___________Zip Code: ______________________

Cell #: ( )____________________ Home #:( )____________________ Work #:( )_____________________

Email Address: ____

Preferred Pharmacy and Location: ____

Patient's Employer: __________________________________Work Phone:( )_______________________________

RESPONSIBLE PARTY (BILL TO) INFORMATION

--Complete this section ***ONLY*** if someone other than the patient is financially responsible—

Responsible Party: (Last) ____________________________(First) ________________________(Middle Initial) _______

Mailing Address:____

City: ____State: ___________Zip Code: _________________________

Cell #: ( )____________________ Home #:( )____________________ Work #:( )_____________________

Social Security #: ____ Birth Date: __________/_______/_________

Relationship to patient: ____

EMERGENCY CONTACT INFORMATION

Name:____Relationship: _______________________________

Cell #: ( )____________________ Home #:( )____________________ Work #:( )_____________________

REFERRAL INFORMATION

Who referred you to our office?____

Who is your Family Physician? ________________________________Location City, State: ___________________

INSURANCE INFORMATION

Primary Insurance Co: ____

Group#: _________________________Policy #: ____

Policy Holder: ____

SS#: ____Birth Date_______/_______/_________

Relationship to patient:____

Secondary Insurance Co: ____

Group#: _________________________Policy #: ____

Policy Holder: ____

SS#: ____Birth Date_______/_______/_________

Relationship to patient:____

_________***Workers' Compensation Co Contact Info:*** ____

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communication and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to Premier Radiology and its agents, assignees and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded /artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

____ ________________________________

Signature of Patient or Responsible Party **Today's Date**

MEDICAL HISTORY

Patient Name: ____
Height________________Weight________________

CONDITION

What are you being seen for today: (include right or left body part)____
Injury: Yes_________No___________ If yes, injury date: ____
Work related: Yes___________No______________ Reported to employer: Yes____________No_____________

Describe how this condition started:

____

SYMPTOMS

Describe your symptoms: ____
Symptoms are: Mild_____Moderate_____Severe______Symptoms are: Constant______ or Intermittent_____________
Check all tests you have had regarding this condition: X-rays___MRI___CT Scan___Bone Scan___EMG___Other_______
Where were these tests performed: ____

REVIEW OF SYSTEMS

Check all the health problems you have had:

___Angina
___Asthma
___Cancer
___Depression/Anxiety
___Diabetes
___Emphysema
___Heart Attack
___Heart Failure
___High Blood Pressure
___Kidney Stones
___Rheumatoid Arthritis
___Seizures
___Sleep Apnea/CPAP
___Stroke
___Thyroid Disorder
___Other____

Check all the surgeries you have had:

___Appendectomy
___C-Section
___Gallbladder
___Heart
___Hysterectomy
___Joint Surgery
___Spine Surgery
___Tonsillectomy
___Other____

FAMILY HISTORY

Check all health problems your immediate family have had and list that relative:
___High Blood Pressure________________________Cancer_______________________Heart Attack______________________

SOCIAL HISTORY

Do you smoke: Yes____No____If yes, how many packs a day: ____
Do you drink alcohol: Yes____No____If yes, how many drinks per day: ____
Have you been treated for alcohol, illegal drug use, or prescription drug abuse:Yes___No___ When:__________________
Are you currently in pain management: Yes______No______
If yes, who is your treating pain management physician: ____

MEDICATIONS

List all medications, dosage and frequency you are currently taking:

Name	Dosage	How Often	Name	Dosage	How Often

ALLERGIES

Are you allergic to: Latex:____Tape____Betadine____
List all medication and/or food you are allergic to and your reaction:

____

CONSENT TO TREAT

I authorize The Bone & Joint Group to provide medical **services to me and authorize the disclosure of protected health information for payment, healthcare operations and treatment to include communication with my providers, pharmacists and hospitals. I understand that I have the right to request The Bone & Joint Group to restrict the use of my protected health information for treatment, payment and healthcare operations and that The Bone & Joint Group may refuse this request. I understand that unless The Bone & Joint Group has taken action in reliance of such consent, that I may revoke this consent by giving written notice. I understand to protect the privacy of my identifiable personal health information; The Bone & Joint Group and its Affiliates, has established a Privacy Policy and guidelines for Privacy Practices with their office.

Signature of Patient/Representative: ____________________________________ Date: ___________________

**Medical services include, but not limited to, office visits, xrays, injections, and surgeries.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, ____, whose signature appears below, authorize The Bone & joint Group and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions from prior years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Signature of Patient/Representative: ____________________________________ Date: ___________________

____

Bone & Joint group Witness Signature

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

One or more of the medications that your doctor has prescribed to you for pain are classified as controlled substances. These medications are very helpful in treating pain and returning patients to work, yet they are subject to abuse. For this reason, the state and federal government closely controls this class of medication. So that we may minimize the possibility of complications associated with the use of controlled medication for pain management, we ask that you read and agree to the following:

1) I am responsible for my controlled substance medications. If the medication is lost, misplaced, stolen or if I use it sooner than prescribed, I understand that it will not be replaced.

2) I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from The Bone & Joint Group. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in the hospital.

3) Refills for controlled substances medications:

   -will be made only during regular office hours. Refills will not be made at night, holidays or weekends.

   -will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

   -will not be made as an "emergency". I will call at least forty-eight (48) hours ahead if I need assistance with a controlled substance medication prescription.

4) I understand that if I violate any of the above conditions, my controlled substance prescription and/or treatment with The Bone & Joint Group may be terminated. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my other physicians, medical facilities and authorities.

I understand that this contract is intended to aid my treating physician and that it is my responsibility to inform my physician of any side effects or complications that may arise from my use of this medication.

My signature below and, use of medication prescribed, indicates that I understand and accept the information and conditions outlined above. I agree that if I am unable to adhere to this agreement, my Bone & Joint Group physician will no longer prescribe this class of medication.

Patient: ______________________________________ Date: __________________________

Witness: _____________________________________

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I, ___________________________________, have been notified of The Bone & Joint Group's privacy policy which describes my rights concerning my health information. I may request a copy of this policy at any time.

____ _________________________

Signature of patient or patient's representative Date

____

Printed name and relationship of patient's representative

____ _________________________

Signature of Bone & Joint Group staff Date

MEDICAL CONSENT FORM

This form authorizes the stated person(s) to inquire or receive the information listed.

NAME OF PATIENT: **DATE OF BIRTH:**

____ ____

(Patient/Parent/Guardian)

I, ____, give the following individual(s) my permission to inquire and/or received the indicated information.

NAME OF INDIVIDUAL	**INFORMATION TO RELEASE (Medical records, prescriptions, appointments, etc)**
____	____
____	____
____	____

Please check one of the following:

_____ This notice is effective only on the following date(s): ____

_____ This notice is effective indefinitely or until I revoke it myself in writing.

____
Patient/Parent/Guardian (Print Name)

____ ____
Patient/Parent/Guardian (Signature) **Date**

VERBAL CONSENT OBTAINED FROM PATIENT/PARENT/GUARDIAN

Name of Patient/Parent/Guardian: ____
Date: ____
Effective thru: ________________________________ ***or indefinitely (unless revoked by patient/parent/guardian)***
Staff member documenting consent: ____

Patient Responsibility

1. I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, x-rays, casting, and any other treatment provided by the doctor or staff.

2. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

3. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

4. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

5. I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

6. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card (if applicable). If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

7. I understand that The Bone & Joint Group is not responsible for approving referrals, out-of-office orders, tests or procedures. All surgeries, MRI's, injections, etc are subject to approval by my insurance company and/or the facility at which it will be performed. When I am referred to another specialist, that specialist will contact me. The Bone & Joint Group does not have access to other doctor's office schedules and/or appointment policies.

8. **I understand that The Bone & Joint Group will be respectful, kind and courteous during the duration of my visits. I MUST also extend the same behaviors to The Bone & Joint Group staff. If at any time I do not feel like I am being treated fairly and respectfully, I MUST notify the Office Manager or Physician. I understand that I can and will be discharged from this practice for rude, obnoxious, hateful, disrespectful, and/or foul-mouthed behavior. I have read and understood The Bone & Joint Group's Respect Policy (posted in lobby).**

9. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. The Bone & Joint Group provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

______________________________________ ______________________________ ___________

Printed Patient Name (and Guardian Name, if applicable) Patient or Guardian Signature Date

____

The Bone & Joint Group Witness

Name ____

Height _____________________

Weight _____________________

REVIEW OF SYSTEMS

Please answer ***ALL*** *questions by checking YES or NO for all that apply in the past* **3 days***:*

	YES	NO
Neurologic		
Tingling/Numbness	___	___
Cardiovascular		
Chest pain	___	___
Dizziness	___	___
Irregular heartbeat	___	___
Shortness of breath	___	___
Respiratory		
Sleep apnea	___	___
CPAP machine	___	___
Genitourinary		
Kidney problems	___	___
Kidney stones	___	___
Endocrine		
Weight loss	___	___
Musculoskeletal		
(other than the reason you are here today)		
Joint pain	___	___
Joint stiffness	___	___
Joint swelling	___	___
Difficulty walking	___	___
Hematological		
Taking anticoagulant	___	___
General		
Night sweats	___	___
Loss of appetite	___	___
Fatigue	___	___
Gastrointestinal		
Blood in stool	___	___
Stomach pain	___	___
Psychiatric		
Alcohol abuse	___	___
Substance abuse	___	___