NEW PATIENT

Crovetti Orthopaedics & Sports Medicine

Today's Date_____ Gender**:** _____

PLEASE COMPLETE THIS FORM ENTIRELY

***Patient Name** _____ SS# _____ DOB ___/____/_____ Age_____

Address _____ Apt# _____

City _____ State _____ Zip_____ Marital Status _____

Preferred Phone – Home or Cell? _____ Secondary Phone – Home or Cell? _____

***Would you like to receive **appointment reminder calls** from our automated calling system? **Circle one**: YES NO

***If you agree to receive email communications from our office** (which may include information about your medical care, any potential surgeries, appointments, billing, etc.), **please provide your email address**: _____

Employer _____ Work Phone_____

_

Occupation_____Department_____

***Parent/Spouse** _____ DOB _____ Phone Number_____

*Pharmacy Name_____ Phone Number_____

*Pharmacy Address _____ *Fax_____

***Emergency Contact** _____ Relation to Patient _____ Phone Number _____
(Not living with you)

***Reason for Visit** _____ Date symptoms started _____

Is this related to an injury? YES / NO If yes, please describe injury _____

Is it work related? YES / NO **Is it auto related? YES / NO**

Have you seen a doctor for your problem? YES / NO If yes, when? _____

Were X-rays or scans taken? YES / NO If yes, when & where?_____

Referred by Dr._____ Phone _____

How did you hear about our office? Circle one: Physician Referral Hospital Referral Friend/Family Internet Billboard

TV Ad Theater Ad Magazine Ad Word of mouth Other_____

***Primary Insurance Company** _____Phone Number_____

Policy ID Number _____ Group Number _____

Primary Insured _____ DOB ____/____/_____ SS# _____

Employer_____ Effective date_____

Relation to Patient: Self_____ Spouse_____ Parent_____

***Secondary Insurance Company** _____ Phone Number_____

Policy ID Number _____ Group Number _____

Primary Insured _____ DOB ____/____/_____ SS# _____

Employer_____ Effective date_____

Relation to Patient: Self_____ Spouse_____ Parent_____

MEDICATIONS (prescribed, OTC, and/or supplements) ***	**DOSE**	**REASON FOR MEDICATION**	**SIDE EFFECTS**

_____ **CHECK IF A MEDICATION LIST IS ATTACHED**

MEDICATION ALLERGIES: _____

PATIENT'S HEIGHT: _____ **PATIENT'S WEIGHT**: _____

REVIEW OF SYMPTOMS: Are you currently having or have you had problems with: (Please describe all YES responses)

Eyes	NO	YES	_____
Ears, Nose, Throat	NO	YES	_____
Lungs, Breathing	NO	YES	_____
Digestion	NO	YES	_____
Bowel Movements	NO	YES	_____
Bladder Problems	NO	YES	_____
Diabetes	NO	YES	_____
High Blood Pressure	NO	YES	_____
Heart Disease	NO	YES	_____
Bleeding Problems	NO	YES	_____
Numbness/Tingling	NO	YES	_____
Blackout/Fainting	NO	YES	_____
Psychological Problems	NO	YES	_____
AIDS/HIV	NO	YES	_____
Cancer	NO	YES	_____
Arthritis	NO	YES	_____
Epilepsy	NO	YES	_____

PAST MEDICAL HISTORY:

Surgeries/Hospitalizations	**Date & Facility Name**	**Complications**

Have you ever had general anesthesia? YES / NO

If yes, did you have any problems with anesthesia? YES / NO If yes, describe_____

SOCIAL HISTORY

Do you work in the home? Y / N Are you a student? Y / N Are you retired? Y / N Do you live alone? Y / N

Are you employed? Y / N Full time/ Part time Occupation _____

Do you exercise? Y / N How often? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

What type of exercise? _____

Do you have a history of substance abuse? Y / N What type? _____

Do you currently smoke? Y / N How many packs per day? _____ How many years? _____

Have you quit smoking? Y / N If yes, when? This year _____ >1 year _____ >5 years _____ >10 years _____ Packs per day for _____ years

Do you drink alcohol? Y / N How often? _____ Daily # of daily drinks_____ _____1-2/week _____ 1-2/month _____1-2/year _____ Never

HIPAA RELEASE

I authorize the following person(s) to be able to obtain my protected health information from Crovetti Orthopaedics & Sports Medicine. By listing someone below (such as a spouse, child, parent, trusted friend) you are giving our staff permission to communicate to another person about scheduling, treatment, care and billing as it pertains to you, the patient. If we do not have the information below, we **CANNOT** speak to anyone other than the patient about any protected health information.

If the patient is a minor, we are allowed to speak to the parent that consented to treatment.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ I wish no one to have access to my protected health information.

Consent for Treatment and Payment

I hereby request treatment by Crovetti Orthopaedics & Sports Medicine and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my treatment to my referring physician(s). I authorize Crovetti Orthopaedics & Sports Medicine to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment(s) directly to Crovetti Orthopaedics & Sports Medicine, for any benefits that I may receive. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or third-party payer is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies, and services along with yearly deductibles. Payment for services is expected at the time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party. I understand that Crovetti Orthopaedics & Sports Medicine does not discriminate against any person on the basis of race, color, religion, gender or gender expression, sexual orientation, age, national origin, disability, or marital status.

Print Patient Name _____

Signature of Patient_____ Date _____
(*if patient is a minor – **DO NOT SIGN** – Parent/Guardian to sign next line)

*Signature of Responsible Party_____ Date _____
(*if patient is a minor)

*Relation to patient _____

Reviewed by Dr. _____Date _____

NEW PATIENT

Patient Name:_____ DOB:_____

Symptom duration? _____ days weeks months years

Pain location? (front, back, inside, outside etc…) _____

Does the pain radiate? (circle one) YES NO

If yes, where does it radiate to: _____

Do you have pain at rest? (circle one) YES NO Does your pain interfere with sleep? (circle one) YES NO

Is the pain CONSTANT or INTERMITTENT? (circle one)

Quality of pain:

☐ Sharp ☐ Aching ☐ Throbbing ☐ Numbness ☐ Stabbing

☐ Shooting ☐ Tender ☐ Burning ☐ Dull ☐ Electrical

Have you had any of the following?

☐ Steroid Injections Last Injection_____ How Many? _____

☐ Viscosupplementation Injections (Synvisc, Orthovisc, Euflexxa, etc) Last Injection _____ How Many?_____

☐ Bracing _____

☐ Physical Therapy How Long? _____

☐ Anti-Inflammatory Medications (past & present - Aleve, Advil, Ibuprofen, etc) _____

Pain at night? ☐ Y ☐ N Back Pain ☐ Y ☐ N Daily pain level (1-10)_____

What makes symptoms better?_____

What makes symptoms worse? _____

Revision Total Joint Questionnaire: **ONLY COMPLETE THIS SECTION IF YOU ARE BEING SEEN FOR AN ISSUE WITH A PRIOR HIP OR KNEE REPLACEMENT.**

Prior Surgery Details: _____ Surgery Date:_____

Surgeon/Hospital (if known) - _____

Any Complications? No Yes - _____

Any Recovery Issues? No Yes - _____

Did Pain Improve After Surgery? No Yes Pain With Sit to Stand? No Yes

Does The Pain Improve When You Start To Walk? No Yes

(Hips Only) Any Dislocations? No Yes- when? _____

Anything Else About Your Original Surgery You Feel Might Be Helpful? _____

_____

CROVETTI ORTHOPAEDICS & SPORTS MEDICINE

PLEASE BE ADVISED OF THE FOLLOWING OFFICE/FINANCIAL POLICIES FOR CROVETTI ORTHOPAEDICS:
The following is a statement of the financial aspect of your medical treatment which must be read and signed prior to any treatment rendered by Crovetti Orthopaedics & Sports Medicine.

PAYMENT: We require that your copayment be paid at time of service. We accept cash, checks, all major credit cards and Care Credit. If payment arrangements are necessary for a balance due, we require that a payment be received every 30 days. Payment on any balance due must be received in the office within 30 days regardless if formal arrangements are made. If your account is placed with our collection agency for lack of regular payments or ignored attempts for collection, you will be responsible for all collection fees, and all future office visits must be paid in full at the time of service. This same policy will be required for all accounts that have filed bankruptcy.

PLEASE NOTE: Our office requires that you provide us with 24 hour notification to cancel appointments for office visits and MRI. You will be charged a $30 fee for any missed office visit and a $50 fee for MRI appointments that you fail to cancel or do not show for.
There is a $20 fee charged for every form completed by our staff or physicians. This includes disability forms & FMLA forms.
There is a 48 hour notice required to cancel or reschedule a surgery with our orthopedic doctors; you will be charged a $100 fee for any surgery canceled or rescheduled with our orthopedic doctors with less than 48 hours' notice.

INSURANCE: We accept assignment of insurance benefits, and our billing department will file a claim with your insurance company as a courtesy. We ask that you provide us with your photo ID (driver's license or passport) and your insurance card(s) as we require proof of insurance, and so that we may obtain pertinent information that is on your insurance card(s) for authorization and billing purposes.

You are responsible to provide us with CORRECT information regarding your insurance and demographic information. You are required to inform us of any changes immediately. Your insurance policy is a contract between you and your insurance company, and you are responsible for knowing your insurance rules regarding co-pays, deductibles, co-insurance, and when a referral or prior authorization is needed for testing or surgery. Every policy is different and we cannot be responsible for knowing what every carrier covers or disallows. Please familiarize yourself with your specific insurance plan benefit. This information is available through your insurance company's plan booklet or their website.

Because of the nature of our practice, insurances frequently request information regarding treatment from the member. You are required to provide this to your insurance in a timely manner. **It is the patient's responsibility to make sure that their provider is paid for treatment received.** Please be aware that the above information is vital and you are equally responsible with Crovetti Orthopaedics & Sports Medicine to understand and confirm your insurance benefits.

AGREEMENTS: In consideration of the treatment provided, the undersigned agrees:
1. That payments under my medical insurance benefits are made to Crovetti Orthopaedics & Sports Medicine, and that COSM may provide information concerning my treatments or that of my minor child to my health insurance carrier or its agents.
2. That I agree to pay for all attorney's fees, court costs, and filing fees, including charges that may be assessed by COSM's collection agency to pursue collection of my account. They also have the right to verify employment.
3. That I have read the Financial Policy above and understand and accept the terms of this policy.

Print Patient Name_____ Date _____

Signature of Patient_____ Date_____
(* If patient is a minor – DO NOT SIGN – Parent or Guardian to sign next line)

*Signature of Responsible Party_____ Date_____
(*If patient is a minor)

*Relation to patient_____

Signature of Witness_____ Date _____

CROVETTI ORTHOPAEDICS & SPORTS MEDICINE

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

We at Crovetti Orthopedics & Sports Medicine are committed to keeping the security and confidentiality of personal information that you provide to us. We do not sell or share patient information with marketing groups outside of our practice and its affiliate groups. This policy covers patient information including personal, financial or health information about a patient or patient relationship. We disclose this policy to you as required by federal and Nevada state regulations. If you have questions after reading this notice, please ask to speak with the practice manager.

How We May Use or Disclose Your Health Information

We protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by us may be used or disclosed to a medical specialist, medical laboratory, or other healthcare provider providing treatment, and to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required By Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders by email, voicemail messages, letters and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- *Disclosures to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or providers without authorization.

You have the following rights with respect to your health information:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and receive a copy of your protected health information.
- The right to request amendment or correction to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

I have read and understand the above notice:

_____ _____

Print Patient Name Patient Signature

_____ _____

Parent/Guardian (**if patient is under 18 years of age**) Date