Med Center Health®
Orthopaedics & Sports Medicine

Date _____

Name _____

Social Security Number _____

Date of Birth _____

Email Address _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

## INSURANCE SUBSCRIBER INFORMATION

Name _____ D.O.B. _____

SSN _____

Address (if different from patient) _____

_____

(Insurance card needs to be rescanned every visit.)

Reason for Visit (Symptoms?) _____

Primary Care or Family Doctor _____

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# Consent, Assignment of Benefits & Financial Agreement

**Consent to Diagnostic Tests, Medical Treatment & Procedures:**
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Med Center Health Orthopaedics & Sports Medicine, their assistants and designees, and other employees of Med Center Health Orthopaedics & Sports Medicine as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

**Assignment of Benefits and Financial Agreement:**
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Med Center Health Orthopaedics & Sports Medicine and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits to a third party payer may be filed by Med Center Health Orthopaedics & Sports Medicine as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claims are filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Med Center Health Orthopaedics & Sports Medicine in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by Med Center Health Orthopaedics & Sports Medicine, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

**Contact Information:**
I agree Med Center Health Orthopaedics & Sports Medicine, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

**Release of Information:**
I authorize the release of all or part of my records, including information stored in Med Center Health Orthopaedics & Sports Medicine corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Med Center Health Orthopaedics & Sports Medicine and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me or any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies; the Social Security Administration, its intermediaries and carriers; state agencies and workers' compensation carriers; as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Med Center Health Orthopaedics & Sports Medicine to make collection of any unpaid charges. I further authorize my employer to release to Med Center Health Orthopaedics & Sports Medicine or any agency engaged for the purpose of collecting unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

**Information Received:**

X _____ (Initial) I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence I am aware of the risks, benefits and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate. I understand a complete prescription history may be obtained from my pharmacy.

X _____ (Initial) I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

X _____ (Initial) This authorization is valid until revoked in writing.

X _____ (Initial) My medical/financial information may also be released to the following persons.

Primary Care Physician _____

Print Patient Name:_____

_____ Signature | _____ Date | _____ Time | _____ Relationship (if not patient)

_____ Witness

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Name _____

Name of Family Physician _____

**Do you now have or have you ever had any of the following symptoms on a recurrent basis?**

**General**
Fatigue ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Night Sweats ❑ Yes ❑ No
Weight Loss ❑ Yes ❑ No

**Head/Eye/Ear/Nose/Throat**
Decreased Smell ❑ Yes ❑ No
Difficulty Swallowing ❑ Yes ❑ No

**Respiratory**
Chronic Cough ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No

**Cardiovascular**
Irregular Heart Beat ❑ Yes ❑ No
Chest Pain/Pressure ❑ Yes ❑ No

**Gastrointestinal**
Abdominal Pain ❑ Yes ❑ No
Diarrhea ❑ Yes ❑ No
Vomiting ❑ Yes ❑ No

**Genitourinary**
Blood in Urine ❑ Yes ❑ No
Frequent Urination ❑ Yes ❑ No

**Endocrine**
Frequent Thirst ❑ Yes ❑ No
Excessive Hunger ❑ Yes ❑ No

**Neurological**
Dizziness ❑ Yes ❑ No
Vision Loss ❑ Yes ❑ No
Headaches ❑ Yes ❑ No
Seizures ❑ Yes ❑ No

**Psychiatric**
Anxiety ❑ Yes ❑ No
Depression ❑ Yes ❑ No

**Skin**
Chronic Rash ❑ Yes ❑ No

**Musculoskeletal**
Back Pain ❑ Yes ❑ No
Difficult Walking ❑ Yes ❑ No
Muscle Weakness ❑ Yes ❑ No
Neck Pain ❑ Yes ❑ No

**Hematologic**
Easy Bleeding ❑ Yes ❑ No
Easy Bruising ❑ Yes ❑ No

**Immunological**
Seasonal Allergies ❑ Yes ❑ No

**Do you have any of the following chronic problems?**

High Blood Pressure ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Coronary Artery Disease ❑ Yes ❑ No
Kidney Disease ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Congestive Heart Failure ❑ Yes ❑ No
Migraine Headaches ❑ Yes ❑ No
Sleep Apnea ❑ Yes ❑ No

Please list any current allergies _____

_____

Please list all surgeries, including approximate date _____

_____

_____

Have you ever been hospitalized other than for surgery? ❑ Yes ❑ No

Please Explain _____

Describe any other previous health problems or concerns not listed above, including any serious accidents or injuries, heart attacks or strokes _____

_____

**FAMILY HISTORY** Has any immediate relative had any of the following health conditions (Only parents, children, or siblings)?

Heart Disease _____ Yes _____ No
Stroke _____ Yes _____ No
Brain Aneurysm _____ Yes _____ No
Cancer (Type _____ ) _____ Yes _____ No

**SOCIAL HISTORY** _____ Married _____ Single _____ Separated _____ Divorced _____ Widowed

Occupation (or previous if retired) _____

Do you use tobacco? ❑ Yes ❑ No ❑ Former What Type? _____

How long have you used tobacco? _____ When did you quit? _____

Do you drink alcohol? ❑ Yes ❑ No How much? _____

**Preferred Pharmacy** _____

**Current Medications** _____

_____

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Orthopaedics & Sports Medicine

HealthCare
ORTHOPAEDIC SURGERY
& SPORTS MEDICINE

Date _____

# MRI QUESTIONNAIRE

Patient Name _____ D.O.B. _____/_____/_____

Height _____ Weight _____

**Please Circle Responses**

1. Are you claustrophobic? **Yes** **No**

   If yes, we can call in medication. What Pharmacy? (Name, City) _____

   _____

2. Do you have any metal in your body? **Yes** **No**

   If yes, where is it located? _____

   What year was the metal placed? _____

3. Do you have a pacemaker? **Yes** **No** If yes, is it MRI Compatible? **Yes** **No**

   **We will need a copy of the implant card.**

4. Do you have aneurysm clip(s)? **Yes** **No** If yes, is it MRI Compatible? **Yes** **No**

5. Do you have artificial heart valve(s) or stent(s)? **Yes** **No**

   If yes, is it MRI Compatible? **Yes** **No**

   **We will need a copy of the implant card.**

6. Do you have a heart monitor? **Yes** **No** If yes, is it MRI Compatible? **Yes** **No**

   **We will need a copy of the implant card.**

7. Do you have an IVC filter? **Yes** **No** If yes, is it MRI Compatible? **Yes** **No**

8. Do you have any other implanted devices (i.e. bladder stimulator)? **Yes** **No**

   If yes, what type of device?_____

   **We will need a copy of the implant card.**

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# TREATMENT WITH CONTROLLED SUBSTANCES

_____ _____
Name Date of Birth

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed, and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose, I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give my permission for my entire prescription history to be obtained from my pharmacy.

_____ _____
Witness Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____
Date Time Relationship to Patient