LAKEWOOD ORTHOPAEDICS AND SPORTS MEDICINE

(469)-341-5676 PHONE (469)-341-5677 FAX

Referring Physician: _____ Primary Care Physician: _____

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Gender: M F Marital Status: _____

Race: _____ Ethnicity: _____ Language: _____

Complete Address: _____

City: _____ State: _____ Zip Code: _____

Phone / Contact Numbers:

Home: _____ Work: _____ Cell: _____

Email Address: _____

Insurance Company Name: _____

Primary Insurance Holder: (If different than above)

Name: _____

Date of Birth: _____

SS#: _____

In case of emergency, who may we contact? _____

Phone Number: _____ Relationship: _____

Is the reason for your visit today a result of any of the following? :

( ) On the job injury ( ) Sports Injury ( ) Auto Accident ( ) other: _____

Preferred Pharmacy Info:

Pharmacy Name: _____ Phone Number: _____

Address or Cross Street: _____

City: _____

HISTORY AND PHYSICAL

(PLEASE COMPLETE ALL 3 PAGES FOR THE PHYSICIAN)

Date: _____

Patient Name: _____ (Circle) Male/Female

Date of Birth: _____ Primary Care Physician/Referring: _____

Reason for Visit: _____

Location: _____ Left _____ Right _____ Both

Describe how and when pain started / how were you injured? : _____

_____

Describe you signs & symptoms / when it occurs / ETC: _____

_____

Average Pain Score: (0 = No Pain: 10 = The most severe pain): _____

PAST MEDICAL HISTORY:

_____ Diabetes Mellitus _____ High Blood Pressure _____ High Cholesterol

_____ Asthma _____ COPD _____ Coronary Artery Disease _____ HIV/AIDS

_____ Blood Clots: If so, were you treated with a blood thinner? _____Yes _____ No

_____ Cancer: If yes, what type? _____

_____ Any other joint, bone or muscle injury? _____

_____ Other: _____

PAST SURGICAL HISTORY:

_____ Patient has had no previous surgeries

Type of Surgery	Date or Year
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY: MEDICAL / SURGICAL:

	Type of Illness	Person(s) Relation to Patient
_____ Cardiac	_____	_____
_____ Cancer	_____	_____
_____ Diabetes	_____	_____
_____ Other	_____	_____

SOCIAL HISTORY:

Smoker _____ Yes ___ No Packs per day: _____quit _____months/years ago

Alcohol _____ Yes ____ No Drinks per day: _____ quit _____ months/years ago

Married _____ Yes ____ No

Children _____ Yes ____ No How many children? _____

Athlete _____ Yes _____No

What school / Athletic Club / etc do you belong to? _____

Name of athletic trainer of coach we can contact on your behalf? _____

Athletic Trainer or Coach Phone # _____

What sport(s) do you play? _____

What is your occupation? _____

Dominant Hand _____ Right _____ Left

CURRENT MEDICATIONS: _____ Patient takes NO medications

_____ Patient has been prescribed medications by another provider

Drug Name	Dose	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (if allergic please provide reaction)

_____ No Known Drug Allergies

_____ No Known Environmental Allergies

Drug Allergies:

_____ Penicillin _____

_____ Sulfa _____

_____ Codeine _____

_____ Other: _____

Environmental Allergies

_____ Latex _____

_____ Adhesive _____

_____ Iodine _____

REVIEW OF SYSTEMS:

Do you have any medical problems with any of the following? Please Describe

_____ Eyes/ Ears/ Nose/ Throat: _____

_____ Cardiac: _____

_____ Pulmonary: _____

_____ Gastrointestinal: _____

_____ Skin / Dermatology: _____

_____ Blood Disorders: _____

_____ Neurological: _____

_____ Psychological: _____

Anything else you would like the doctor to know about your injury/illness?

_____

_____

_____

_____

LAKEWOOD ORTHOPAEDICS & SPORTS MEDICINE

TERRY K. GEMAS, M.D.

FINANCIAL POLICY AND BILLING PROCEDURES

PAYMENT IS DUE AT THE TIME OF SERVICE
REFERRALS MUST BE PROVIDED IF NECESSARY, PRIOR TO VISIT.

The fees that we charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance companies can vary greatly on the types of coverage available. You will need to check with your insurance company regarding the specific coverage you may have.

If you are an HMO or PPO patient, it is your responsibility to make sure all referral information from your primary care physician is in our office prior to your visit. We will require this referral authorization before we can render any services to you. If you do not provide the appropriate referral information at the time of your visit and services are rendered to you, you agree to pay our doctors their billed rate as a fee-for-service patient foregoing any health care insurance coverage you may otherwise have had.

If you have Medicare, we will file the claim forms representing services rendered to you as "assignment accepted".
If you have any secondary insurance, you agree to provide us with this information at the time of your visit so that we may file the appropriate claim forms for you.
All patients are responsible for paying their annual deductible balance, co-insurance payments, and any non-covered service charges at the time of your visit.
We do not accept Medicaid patients other than for emergency room services. If you are a Medicaid patient or anticipate applying for Medicaid for the payment of the services rendered to you, by signing this agreement you understand that our doctor is accepting you as a private-pay patient and not as a Medicaid patient for any non-emergent services rendered to you and that you will be responsible for paying for the non-emergent services you receive from any of our doctors. We will not file a claim to Medicaid for the non-emergent services provided to you.

I, _____ (Patient or legal guardian) HAVE READ THE ABOVE INFORMATION AND FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL APPLICABLE CHARGES AT THE TIME SERVICES ARE RENDERED. I AUTHORIZE THE RELEASE OF MY MEDICAL AND BILLING INFORMATION FOR THE PURPOSE OF PAYMENT OF INSURANCE BENEFITS TO MYSELF OR TO MY PHYSICIAN. I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY.

SIGNATURE _____ DATE: _____

NO SHOW POLICY

A "no show" is someone who misses an appointment without cancelling 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients chart as a "no show". An administrative fee of **$75.00** may be billed to the patients account. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment within the 24 hour time period, (1) working day in advance. A copy of the letter will be placed in the patient's file. Three "no shows" may result in the temporary suspension of services. In order to reinstate services the patients may be required to pay all fees associated with the no show policy.

Patients who are more than 15 minutes late for an appointment may be subject to being rescheduled.

Patient Name: _____

Responsible Party: _____

Signature: _____

Date: _____

MEDICATION REFILL POLICY

ALL PAIN MEDICATION MUST BE PHONED OR FAXED INTO OUR OFFICE DURING NORMAL BUSINESS HOURS

MONDAY-THURSDAY 8:00AM – 4:00 PM

FRIDAY 8:00AM – 12:00 NOON

IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY WITH THEIR PHARMACY AND OUR OFFICE THAT IT HAS BEEN RECEIVED PRIOR TO THE ABOVE DEADLINE TIMES.

PLEASE NOTE THAT THERE WILL ABSOLUTELY **NOT** BE ANY REFILLS GIVEN ON THE WEEKENDS.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Lakewood Orthopaedics and Sports Medicine

Terry Gemas, MD

Consent to Treat

I authorize Lakewood Orthopaedics and Sports Medicine to provide me with reasonable and proper medical care according to today's standards. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to outcome of any procedure and or treatments

Signature: _____ Date: _____

Disclosure

Do you give consent for Lakewood Orthopaedics and Sports Medicine staff to leave messages with pertinent medical information and or appointment reminders?

Yes/No Phone Number: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Marketplace Patients

Do you currently receive a premium tax credit or subsidy for your health insurance plan? Yes/No

If you have purchased insurance from health marketplace and receive tax credit subsidy for health insurance you must provide documentation of active coverage on a month to month basis.

I _____ am currently on health insurance purchased through the health care marketplace. I am aware that I am responsible for verification of coverage. In the event I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally for all charges at the time services are rendered.

Signature: _____ Date: _____

HIPPA Statement

I, _____ understand that as part of my health care, Lakewood Orthopaedics and Sports Medicine, originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment as well as plans for future care or treatment. I understand that as part of my treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity. I understand I have been provided with a Notice of Privacy Practices that provides a more complete description of how Lakewood Orthopaedics and Sports Medicine may use and disclose my protected healthcare information. I agree that Lakewood Orthopaedics and Sports Medicine may do the following unless I specifically give direction prohibiting such activity: *Send appointment reminders and test results to the phone number and or address I provided

* Send routine correspondence such as billing statements to the address I have provided

* Leave messages on an answering machine and or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the practice on medical or billing matters.

Signature: _____ Date: _____