LAKEWOOD ORTHOPAEDICS AND SPORTS MEDICINE

(469)-341-5676 PHONE 1469)-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 injure: ___________________________________

____

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

Druo Allergies:

______Penicillin ______________________

______Sulfa ______________________

______Codeine ______________________

Environmental Allergies

______ Latex ______________________

______ Adhesive ______________________

______Iodine ____

____Other: _

_

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 0RTH0PAED1CS & SPORTS MEDICINE

TERRY K. GEMAS, M.D.

FINANCIAL POLICY AND BILUNG PROCEDURES

PAYMENT IS DUE AT THI 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.

Please also note your physician may have financial ownership in some of the institutions (i.e., surgical centers) he will treat you at. In no way will this negatively influence your care as we follow all federal and state rules.

|,____(Patient or legal guardian) HAVE READ THE ABOVE INFOR MATION AND FULLY UNDERSTAND THAT 1 AM RESPONSE BLE FOR THE PAYMENT OF ALL APP LICABLE CHARGES FROM SERV ICES ARE REND ERED. AUTHORIZED| THE RELEASE OF MY MEDICAL AND BILLING IN FORMATION FOIL THE PURPOSE OF PAYMENT OF lNSU RANCE BEN EFITS TO MYSELF OR TO MY PHYSICIAN. I AG REE THAT I AM FINANCIALLY RESP0 NSIBLE FOR ALL CHARGES NOT COVE RED 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. We require this cancelation to be done through verbal communication with our office staff. Voicemail cancelations will not be sufficient.

A failure to arrive for the scheduled appointment will be recorded as a no show, and an administrative fee of **$100.00** may be billed to the patient. A letter may be sent to the patient alerting them that they missed an appointment and failed to notify our office in a timely manner, 24 hour time period. The patient may be required to pay the administrative fee prior to another appointment. After three " no shows" the patient may be temporarily or permanently dismissed as a patient. In order to reinstate services, the patient may be required to pay all fees associated with the "no show" policy.

Surgery Cancelation Policy

If the patient is choosing to cancel or reschedule a surgery, we require a **7 day notice.** This cancelation or reschedule must be verbally communicated with our office staff; voicemail cancelations will not be sufficient.

Many entities are affected when sufficient notice of cancelation or reschedule is not given within a timely manner. A failure to cancel or reschedule your appointment will result in a **$750.00** administrative fee. This fee must be paid prior to making future appointments. Failure to pay, or make payment arrangements to pay this administration fee, will result in temporary or permanent dismissal from Lakewood Orthopaedics and Sports Medicine. In order to reinstate services, the administration fee has to be paid in full.

By signing this, you have acknowledged and agree to both the "No show" and "surgery cancelation" polices:
Patient's 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 8:0OAM - 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 NOTBE

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: _______________________