PATIENT INFORMATION

NAME: _____ DOB: _____ GENDER Female ____

SSN: _____ ETHNICITY (check one): ☐ Not hispanic/latino ☐ Hispanic/Latino ☐ Decline RACE: _____

PREFERRED NAME: _____ EMAIL ADDRESS: _____

(Provide your e-mail address to receive our newsletter and patient portal invitation)

PREFERRED LANGUAGE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

FAMILY PHYSICIAN: _____ PHONE No: _____

(please provide first and last name)

REFERRING PHYSICIAN: _____ PHONE No: _____

(please provide first and last name)

DATE OF INJURY/CONDITION: _____ AREA OF BODY INJURED/ CONDITION: _____

HOW INJURY/CONDITION OCCURRED : _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SSN: _____ DOB: _____ SSN: _____ DOB: _____

POLICY ID: _____ POLICY ID: _____

RELEASE OF PROTECTED HEALTH INFORMATION

Under the Federal HIPAA Privacy Rule, HROSM is not allowed to release specific patient information to other individuals or companies without authorization from the patient. This may include appointment and billing information as well as treatment information or copies of your medical records. If you wish to have your information released to individuals or companies (i.e. family members, physicians, attorneys, disability companies) please list these individuals below:

I authorize HROSM to release certain medical information about me to the following individuals or companies:
Please note Full PHI will include any and all information: (including personal, health, demographics, claims, billing and medical records

NAME: _____ ☐ Full PHI ☐ Partial PHI

NAME: _____ ☐ Full PHI ☐ Partial PHI

NAME: _____ ☐ Full PHI ☐ Partial PHI

If Partial Information is checked please list the type of information you would like to share in the section below (such as specific treatments, dates of service or billing details):

_____

_____

For more information regarding HIPAA regulations, I understand that I may request a copy of the Notice of Privacy Practices Form.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Hampton Roads Orthopaedics & Sports Medicine
Payment Policy

PAYMENT POLICY AND INSURANCE ASSIGNMENT RELEASE: The payment for services is due on the day services are rendered, unless other means of payment are agreed upon by the undersigned and Hampton Roads Orthopaedics & Sports Medicine or its affiliated service groups. I authorize the filing of claims (electronically and/ or hard copy) against any insurance in force and other third party payer including Medicare, Medicaid, or Workers' Compensation carriers, and further assign direct payments to Hampton Roads Orthopaedics & Sports Medicine. The undersigned understands that he/she is responsible for payment of any charge not covered by this agreement, and that monies recovered in excess of the patients' indebtedness will be refunded. In the event of any default on any payment due Hampton Roads Orthopaedics & Sports Medicine and its affiliated service groups, I agree to pay all costs including 33 1/3% collections and attorney fees. I also authorized Hampton Roads Orthopaedics & Sports Medicine or agents to speak to me regarding my balance. I authorize the release of any medical information to process claims for services rendered I understand there is no guarantee of treatment outcomes.

If I do not have active insurance or a valid referral (if applicable) today, I understand that I will have to pay for today's visit. I understand that if my insurance company requires a referral, I have to inform Hampton Roads Orthopaedics & Sports Medicine. I also have to get a referral for this date of service. The estimated cost of services for today's' visit is $363. I understand that this payment is non-refundable. **By signing this form, I agree that I will be paying for today's' visit if my insurance company does not pay**.

If I have Medicare, Medicaid, or Tricare, I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare/Medicaid/Tricare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

OWNERSHIP: I have been made aware that the surgeons of Hampton Roads Orthopaedics & Sports Medicine have ownership in HROSM Physical Therapy, HROSM Interventional Spine & Sports Institute, HROSM of Williamsburg, HROSM Foot and Ankle Center, Open Multi-Positional MRI Center, and Hampton Roads Urgent Care, and the Mary Immaculate Ambulatory Surgical Center.

APPOINTMENT CANCELLATION/NO-SHOW POLICY: In order to provide the best care to our patients, we ask that you notify us 24 hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so will result in a missing appointment fee of $50.00.

Patient/Parent/Guardian **PRINT** Name:_____

Patient/Parent/Guardian **Signature**:_____ 

Date: _____

Witness **PRINT** Name:_____

Witness **Signature**:_____

Date:_____

Open Multi-Positional MRI Center
Hampton Roads Orthopaedics & Sports Medicine
HROSM
Keeping Bodies in Motion

Thomas E. Fithian, M.D., FAAOS
Jon H. Swenson, M.D., FAAOS
Anthony T. Carter, M.D., FAAOS
Daniel R. Cavazos, M.D., FAAOS
John W. Aldridge, M.D., FAAOS
Adrian T. Baddar, M.D., FAAOS
Kinjal B. Sohagia, M.D.
Brendan M. McConnell, D.P.M., FACFAS
Nelson G. Keller, D.P.M., FACFAS
Alexander Lambert, II, M.D.
Scott Bradley, M.D.
Rebecca Shoemaker, M.D.

E-PRESCRIBING WAIVER

Pharmacy Benefits Managers (PBM) Consent:

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By giving your consent you are agreeing that Hampton Roads Orthopaedics & Sports Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

☐ Consent **Given**: _____ Date: _____

Initials

☐ Consent **Denied**: _____ Date: _____

Initials

Virginia Prescription Monitoring Program:

Please be advised that Hampton Roads Orthopaedics & Sports Medicine utilizes the Virginia Prescription Monitoring Program.

Patient Name (printed) _____ Date of Birth: _____

Signature of patient (or representative)_____

Date: _____ Relationship if other than patient: _____

MEDICAL HISTORY FORM

NAME:_____ **AGE:**_____

OCCUPATION:_____ **HEIGHT:**_____ **WEIGHT:**_____ **DOB:**_____

☐**Right Handed** ☐**Left Handed** **PREFERRED PHARMACY:**_____ **PHARMACY PHONE:**_____

ALLERGIES (Drug/Food/Latex/Metal):_____

_____

CURRENT MEDICATIONS INCLUDING HERBAL SUPPLEMENTS/ DOSAGE: _____

_____

MEDICAL HISTORY

Have you had any of these problems?:

☐AIDS/HIV
☐Asthma
☐Bleeding Problems
☐Blood Clots (DVT)
☐Blood Clot in Lung (Pulmonary Embolism)
☐Bone Infection
☐Cancer: _____
☐Carpal Tunnerl Syndrome
☐Chronic Obstructive Pulmonary Disease
☐Cushing's Syndrome
☐Dental Cavities/ Periodontal Disease
☐Problems with Anesthesia
☐Depression
☐Diabetes
☐Dislocated Joint: _____
☐Fibromyalgia
☐Fractured Bone: _____
☐Glaucoma
☐Gout
☐Heart Disease
☐Hepatitis: _____
☐Herniated Disc
☐Hiatal Hernia
☐History of MRSA or other skin/joint infection
☐High Blood Pressure
☐Kidney Stones
☐Liver Disease
☐Migraine Headaches
☐Mitral Valve Prolapse
☐Neck Injury
☐Osteoarthritis
☐Osetoporosis
☐Paralysis-partial or complete
☐Parkinson's Disease
☐Peripheral Vascular Disease
☐Sleep Apnea
☐Neck Radiataion
☐Reflux
☐Renal Failure/Dialysis
☐Rheumatoid Arthritis
☐Seizures
☐Scoliosis (Curved Spine)
☐Stomach Problems
☐Stroke
☐Thyroid Problems
☐Tuberculosis
☐Ulcer Disease
☐Rheumatic Fever
☐Vision or hearing abnormalities
☐Other:
_____
_____

SURGICAL HISTORY

Have you ever had an operation to the following areas?: If so, please specify with approximate dates

☐No history of surgery
☐Abdomen: _____
☐Back/Neck: _____
☐Cancer: _____
☐Extremity: _____
☐Fracture: _____
☐Hysterectomy: _____
☐Kidney: _____
☐Lung: _____
☐Open Heart Surgery: _____
☐Pacemaker Insertion: _____
☐Defibrillator Insertion: _____
☐Stent Insertion: _____
☐Other: _____

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: **If YES, who?:**

☐Arthritis: _____
☐Cancer: _____
☐Diabetes: _____
☐Heart Disease: _____
☐High Blood Pressure: _____
☐Osteoporosis: _____
☐Problems with anesthesia: _____
☐Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT):
_____
☐Other: _____

SOCIAL HISTORY

DO YOU:

Consume Alcoholic Beverages: ◯ YES ⊙ NO If yes, how much/often:_____
Consume Tobacco Products: ◯ YES ⊙ NO If yes, how much/often:_____
Are you a past smoker: ◯ YES ⊙ NO If yes, how long ago did you quit?:_____

PATIENT SIGNATURE: _____ **DATE:** _____

Entered by: _____ Date: _____ Reviewed by: _____ Date: _____