PATIENT INFORMATION FORM

LAST NAME:_____FIRST NAME:_____MIDDLE__

STREET ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE #_____

CELL PHONE#_____

WORK PHONE #_____

S.S. #_____ DATE OF BIRTH_____

EMAIL ADDRESS_____

(This will give you acces to our portal. from there you can pay your bill, access records,send messages,view your upcoming appointments,etc.)

CIRCLE ONE: MARRIED -SINGLE -DIVORCED -WIDOWED / MALE - FEMALE

WHAT PHARMACY DO YOU USE?_____

WHO IS YOUR FAMILY DOCTOR?_____

EMERGENCY CONTACT_____RELATION_____

NAME_____PHONE_____

****

CIRCLE THE FOLLOWING THAT YOU HAVE: HIGH BLOOD PRESSURE, HEART TROUBLE, KIDNEY-BLADDER PROBLEMS,ULCERS,FEVERS,DIABETES

DO YOU USE TOBACCO?_____ ALCOHOL?_____

HEIGHT_____WEIGHT_____LATEX ALLERGY?_____

PLEASE LIST ANY DRUG ALLERGIES?_____

REASON FOR VISIT TODAY_____

LIST ANY CURRENT
MEDICATIONS_____

IS THIS A WORKERS COMP INJURY? YES OR NO.....IF YES COMPLETE THE FOLLOWING:

CLAIM NUMBER_____

CLAIMS MANAGER_____

MANAGERS PHONE_____

MANAGERS FAX_____

DATE OF INJURY_____

HAVE YOU MISSED WORK DUE TO THIS CONDITION, IF SO WHAT DATES?

_____

IS THIS A MOTOR VEHICLE ACCIDENT? YES OR NO.....IF YES, PLEASE COMPLETE THE FOLLOWING

DATE OF ACCIDENT_____AUTO INSURANCE CO._____

POLICY #_____INSURED'S NAME_____

ATTORNEY'S NAME_____PHONE#_____

****

INSURANCE INFORMATION

PRIMARY INSURANCE CO._____

POLICY HOLDER NAME_____

SECONDAY INSURANCE CO._____

POLICY HOLDER NAME_____

RESPONSIBLE PARTY (IF OTHER THAN SELF)

NAME_____D.O.B._____

ADDRESS_____

PHONE
#_____S.S#_____

RELATIONSHIP TO PATIENT_____EMPLOYER_____

HAVE YOU BEEN TO THE ER FOR THIS PROBLEM?_____ IF YES, WHERE?_____WHEN?___

HAVE YOU SEEN AN ORTHOPEDIC DOCTOR BEFORE?_____IF YES, WHERE_____

IS THIS A PREVIOUS INJURY?_____PREVIOUS PHYSICIAN_____

LIST ANY PREVIOUS
OPERATIONS_____

_____

YOU HAVE MY PERMISSION TO SPEAK WITH_____ABOUT MY MEDICAL TREATMENT OR BILL.YOU HAVE MY PERMISSION TO LEAVE A MESSAGE ON MY VOICEMAIL: YES OR NO

It is your responsibility to notify us if there is any change to whom we may discuss your medical treatment or bill. To members of HMO/PPO Insurances: We will contact your insurance companyand your PCP to request pre-certification of all office visits,MRI's, PT,Lab studies,etc.,but it would be in your best interest to check with your insurance company before going to such appointments.

I hereby authorize Summit Orthopedics to release information aquired during the course of my treatment and examination to the health care financing administration and it's agents, or any otherthird-party carrier,my PCP or referring physician as necessary to secure payment of any benefits due to me. This would include information needed to secure necessary authorizations and/or pre-certs for treatments. I hereby assign payment of said benefits to include Medicare benefits directly to Summit Orthopedics. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

_____

Signature of responsible party

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information {PHI}. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner {check all that apply}

☐ Home Telephone_____

- ☐ O. K. to leave message with detailed information
- ☐ Leave message with call-back number only.

☐ Written Communication

- ☐ O. K. to mail to my home address
- ☐ O. K. to mail to my work/office address
- ☐ O. K. to fax to this number_____

☐ Work Telephone _____

☐ Names of Family & Friends who may contact Summit Orthopedics on your behalf_____

_____

_____

_____

Patient's Signature

_____

Date

_____

Print Name

_____

Birthdate

The Privacy Rule generally requires healthcare providers to take the reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures or TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized.
(2) Type key: T=Treatment Records; P=Payment information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E= E-mail; O=Other

Summit Orthopedics

4607 MacCorkle Ave. S.W., Suite 401
So. Charleston, WV 25309
Telephone: {304} 414-2120
Fax: {304} 414-2127

Phillip D. Surface, D. O.
Diplomat, American Osteopathic Board of Orthopaedic Surgery
Diplomat, National Board of Osteopathic Examiners

Matthew D. Stover, D.O.

Financial Policy Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

In order to achieve the office goals of providing the finest medical care at the lowest possible cost, we need your assistance, and your understanding of our payment policy:

YOUR PORTION OF PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, OR VISA/MASTERCARD. WE ALSO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

All patients must complete our patient information form before seeing the doctor.

In order to keep our fees to minimum, we require that you pay your portion at the time of service so that we do not have to send bills.

We gladly accept assignment of insurance, if we are participating providers of that insurance. However, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, if your insurance company does not pay for services rendered, it is your responsibility.

By law your insurance carrier must remit payment or deny your claim within 30 days. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problems. If your insurance company has not paid your account in full within 90 days, the balance will become your responsibility.

Our office firmly believes that a good doctor/patient relationship is based upon understanding and good communications. Thank you for understanding our financial policy. If you have any questions about financial arrangements, please feel free to talk with our billing supervisor or office manager. We will make every effort available to you to clarify any misunderstanding you have concerning your balance. We are here to help you.

Sincerely,

Phillip D. Surface, D. O.

Matthew D. Stover, D.O.

I have read, understand and agree to this financial policy.

X _____
Signature of Patient

X _____
Date

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Patient Responsibilities

This office is committed to providing you with the best possible medical care. To do this, we need for you to understand your responsibilities as a patient.

A patient or legal guardian has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters to the doctor or his office staff.

A patient or legal guardian is responsible for making it known whether he or she understands the treatment plan, what is expected of them and following the treatment plan recommended by the doctor.

The patient or legal guardian is responsible for keeping appointments and, when unable to do so for any reason, for notifying the doctor. You are expected to be on time for your appointment.

Our policy is that if your are 15 minutes late for your appointment, we will reschedule you to a later date. If you are required to bring x-rays or medical records and do not have them, you will be rescheduled. If your insurance company requires prior authorization, this is your responsibility. Please notify our office before your appointment date to make sure we have the authorization needed or we will have to reschedule.

The patient or legal guardian is responsible for their actions if they refuse treatment or do not follow the doctor's instructions. If the patient cannot follow through with the treatment, they are responsible for informing the doctor.

The patient or legal guardian is responsible for assuring that the financial obligation for their health care is fulfilled as promptly as possible and for providing information for insurance.

The patient is responsible for being considerate to the personnel and respectful of the property of this office.

I have read, understand and agree to the Patient Responsibilities.

X _____ X _____

Signature of patient Date

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Pain Contract

1. Pain medications are to be received from only one physician or one physician's office. The present prescribing physician is to be designated to our office.
2. Medications are to be received from only one pharmacy designated to this office. If this changes, you are to call this office with the name, address and a telephone number of the new pharmacy or inform us during the next clinic visit.
3. There will be no refills written on a Schedule II prescription. ***There will be no medications called in or filled after hours or on weekends. Prescriptions are to be obtained during an office visit.*** If medications are lost or stolen then a police report is required before a prescription will be considered for refill.
4. You may be required to undergo randomized urine or blood screening for use of medications other than those prescribed by your designated physician. You should not use alcohol or illicit drugs while taking this medication.
5. You may be required to undergo a randomized quantity account for prescribed medicines by your designated physician. Medications are prescribed only for patient's use.
6. Your case may be subject to review by the State Board of Pharmacy, the State Police or the DEA.
7. Evaluation by a behavioral medicine specialty {psychiatry or psychology} for risk versus benefit or long term use of narcotic/controlled substance medications will be obtained. Follow up visits will be scheduled as needed.
8. Narcotic/controlled substance medications are potentially addictive. The benefit must be weighed against the risk. This must be done on an individual basis.
9. You should not drive a motor vehicle or engage in potentially activities while taking this medication unless approved by prescribing physician.
10. Any violation of this contract is reason for dismissal from our care.

This is an office statement regarding prescription and use of controlled substances. These medications have been determined to have addictive or abuse potential. These include pain medications/narcotics {Lortab, Lorcet, Vicodin, Morphine, Oxycodone, Hydrocodone, Percocet, Tylox, OxyContin, MS Contin}, Valium, Xanax, Soma, Tylenol 3 & 4 and other similar compounds. If you have any questions whether one of your medications is a narcotic/controlled substance, please ask. If you have any questions regarding the above, please feel free to bring them up for discussion. The above is intended for the safe use of these medications.

X_____
Patient's Signature

X_____ X_____
Witness Date

Summit Orthopedics

Patient name _____Date of birth_____

Our practice has adopted an electronic medical records system in order to improve the quality of our services. This system also allows us to collect and review your "medication history". A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. The list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to us helping to treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat HIV/AIDS and medications used to treat mental heath conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medications, supplements, or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for Summit Orthopedics to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

_____

Patient/Guardian signature Date

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OFFICE POLICY REGARDING MISSED APPOINTMENT

We appreciate being able to serve your medical needs, and understand that sometimes things get in the way of the very best intentions. It is important that we communicate our concerns when missed appointments occur.

We understand that rescheduling is sometimes necessary. Our policy is that we require advance notice the business day prior to your appointment should you need to reschedule or cancel. This allows us time to offer that appointment to another patient.

We simply ask that for the benefit of others who are waiting for medical care, you please consider the importance of the time you reserve. It is never our desire to lose anyone from our care. However, in order to insure that missed appointments do not occur in the future, we are now updating the following policy:

*****MISSED APPOINTMENT FEE: $25.00*****

Thank you for your understanding and cooperation regarding this concern.

My signature below confirms that I have received a copy of this policy.

_____ _____

Patient Signature Date

_____

Print Name