Date: _____ **Medical History** **DOB:** _____

1. Name: _____ Age _____ □ Right handed □ Left handed
2. Occupation: _____
3. Describe problem (be specific) _____
4. Duration of symptoms: _____
5. Date of Injury: _____ Work Injury □ No □ Yes Dates you have been off work _____
6. Side □ Right □ Left □ Both
7. Family Physician's Name and location: _____ Referred by: _____
8. Medication **Allergies** (list all) _____
9. Have you tried □ Physical Therapy □ Braces □ Shots
10. Have you tried over the counter medicine for this problem? □ Tylenol □ Aleve □ Advil/Motrin (Ibuprofen)
11. Current **Medications** (list all medications taken for any reason – not just for your orthopedic problem)
    (if you have a list of your medications/surgeries with you, you may ask the staff to make a copy instead of filling in the blanks below)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

12. List all previous **Surgeries** (Orthopedic or otherwise):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

13. **Medical problems** (check all that you have now or have had in the past)

___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Blood Clots (DVT/PE)
___ Cancer
(type of cancer)
_____
___ Heart Failure (CHF)
___ Depression
___ Diabetes
___ Emphysema/COPD
___ Fibromyalgia
___ Gout
___ Heart Attack/Chest Pain/Angina
___ Cardiac Stents
___ Cardiac Bypass surgery
___ Pacemaker
___ High Blood Pressure (HTN)
___ High Cholesterol
___ HIV/AIDS
___ Kidney Disease or Kidney Failure
___ Dialysis
___ Liver Disease
___ Hepatitis (A, B, or C)
___ Multiple Sclerosis
___ Seizures
___ Stroke or Mini/Stroke
___ Thyroid Problems
___ Ulcers

Other problems not listed above _____

14. **Health Habits** Do you smoke: □ No □ Yes Amount _____

    Drink Alcohol: □ No □ Yes Frequency _____ Other Drugs (list): _____

15. **Family History** Please list the problems (from the list above) that run in your immediate family (parents or siblings)

    _____

16. **Symptoms** (Please check symptoms you currently have or have had in the past 6 months)

General ___ Fever
___ Chills
___ Sweats at Night
___ Unexplained Weight Loss
Skeletal ___ Joint Pain
___ Weakness
___ Joint Stiffness

GI ___ Nausea
___ Vomiting
___ Diarrhea
___ Blood in Stool
GU ___ Frequent Urination
___ Pain with Urination
___ Blood in Urine

ENT ___ Hearing Loss
___ Sinus Problems
Skin ___ Rash
___ Hives
___ Easy Bruising
Eyes ___ Blurred Vision
___ Poor Vision

CV ___ Chest Pain
___ Palpitations
___ High Blood Pressure
Neuro ___ Headaches
___ Numbness/Tingling
Resp ___ Shortness of Breath
___ Persistent Cough

_____ _____ _____ _____

Doctor's Signature & Date Doctor's Signature & Date Doctor's Signature & Date Doctor's Signature & Date

Patient Intake For Minors

Section A

Patient Name_____ (_____) **DOB:** _____
Last **First** **Middle** **Maiden**

Preferred Name _____ Sex M F ☐ **Social Security #** __ __ __ - __ __ - __ __ __ __

Race (please circle): African American/Black American Indian/Alaskan Native Asian Caucasian/White Native Hawaiian/Pacific Islander Other:_____

Ethnicity (please circle): Hispanic/Latino Non Hispanic Unknown Declined

Age _____ Marital Status _____ **Preferred Pharmacy Name and address:**_____

Patient Address: _____**City** _____ **State** ____ **Zip**_____

Mailing Address (if different than home address) N/☐_____ City_____ State_____Zip _____

Please check preferred method of contact: ☐ Home _____ ☐ Work_____ ☐ Text ☐ Cell_____ ☐ Email _____

Insurance Policy Holder: ☐ **Self** (If the patient is the policy holder you may skip this section).

Name _____ Relationship _____ Social Security Number _____ DOB_____

Employer_____ Occupation_____

Name/Relationship of Adult with patient today_____

Name/Relationship of person legally responsible for patient_____

Parent/Guardian Name _____ **DOB**_____ **Social Security #**__ __ __ -__ __ -__ __ __ __

Relationship to Patient_____

Parent/Guardian Address: _____ **City** _____ **State** ____ **Zip**_____

Parent/Guardian Employer Name & Address_____

Other Parent's Name_____ **DOB**_____ **Social Security #**__ __ __ -__ __ -__ __ __ __

Relationship to Patient_____

Other Parent/Guardian Address: _____ **City** _____ **State** ____ **Zip**_____

Other Parent/Guardian Employer Name & Address_____

Family Doctor's Name and address: _____

Does this visit relate to an injury? ☐ Yes (see section B) ☐ No (skip section B) Date/Time of injury: _____

Are you represented by an attorney regarding this visit or this problem? ☐ No ☐ Yes

Name of attorney (if you answered Yes) _____

Attorney's Location _____ Attorney's Telephone # _____

Parent/Guardian Signature:_____ **Today's Date**_____

Patient Intake

Section A

Patient Name_____ (_____) **DOB:** _____
Last **First** **Middle** **Maiden**

Preferred Name _____ Sex M ☐ F ☐ **Social Security #** __ __ __ - __ __ - __ __ __ __

Race (please circle): African American/Black American Indian/Alaskan Native Asian Caucasian/White Native Hawaiian/Pacific Islander Other:_____

Ethnicity (please circle): Hispanic/Latino Non Hispanic Unknown Declined

Age _____ Marital Status _____ **Preferred Pharmacy Name and address:**_____

Patient Address: _____**City** _____ **State** ____ **Zip**_____

Mailing Address (if different than home address) ☐ N/A _____ City_____ State_____Zip _____

Please check preferred method of contact: ☐ Home _____ ☐ Work_____

☐ Cell_____ ☐ Text Message_____ ☐ Email _____

Employer_____ Occupation_____

Employer Address_____ Hire Date _____ Fulltime ☐ Part-Time ☐

Insurance Policy Holder: ☐ **Self** (If the patient is the policy holder you may skip this section).

Name _____ Relationship _____ Social Security Number _____ DOB_____

Employer_____ Occupation_____

Emergency Contact _____ **Relationship**_____ **Phone**_____ **DOB**:_____

Family Doctor's Name and address: _____

Does this visit relate to an injury? ☐ Yes (see section B) ☐ No (skip section B) Date/Time of injury: _____

Section B – Injury / Accident Related

Is this a work related injury? ☐ No ☐ Yes

Do you have authorization to bill Workman's Compensation? ☐ No, bill my health insurance. ☐ Yes*

Is this an accident (non-work related) that will be filed through a third party insurance? ☐ No ☐ Yes**

Are you represented by an attorney regarding this visit or this problem? ☐ No ☐ Yes

Name of attorney (if you answered Yes) _____

Attorney's Location _____ Attorney's Telephone # _____

***If you checked Yes, that you have WC authorization, please ask for a green sheet.**

****If you checked Yes, that you will be billing a third party, please ask for an orange sheet.**

Your Signature:_____ **Today's Date**_____

Rev: 1/16/2017

SHENANDOAH VALLEY
ORTHOPEDICS
& SPORTS MEDICINE

Thomas R. Pereles, MD
Jack F. Otteni, MD
Ramon C. Esteban, MD
D. Brian Dean, MD
Franklin A. Fisher, PA-C
Roberto Lianez, NP

Patient's Consent for Orthopedic Associates, Ltd.
Authorization for Release of Protected Health Information

Patient Name: _____ **SS#** _____

1) **Authorization to Dislose PHI (Protected Health Information.** I hereby authorize Shenandoah Valley Orthopedics & Sports Medicine, my healthcare provider, to disclose any and all of my medical protected health information ("PHI") to the persons indicated below.

2) Persons to Whom Disclosure May be Made; Provider may disclose my PHI to the following persons:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

3) **Purpose of Disclosure:** The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, to know the status of my health, and/or to pick up anything pertaining to my treatment from Shenandoah Valley Orthopedics on my behalf.

4) **Expiration of Authorization:** This authorization shall continue until I revoke it in writing, which I may do at any time by sending a letter addressed to the Privacy Officer at Shenandoah Valley Orthopedics.

5) **Conditioning of Treatment.** Provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this consent.

6) **Redisclosure by Recipient.** I understand that once the Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law.

7) **Ackwnoledgment of Reading and Agreement**. I have read and understand this authorization.

I understand that if I send someone on my behalf to pick up information from Shenandoah Valley Orthopedics & Sports Medicine that said person must be listed on this form.

_____ _____
Patient Name or Representative Date

If Representative Signs, state the Representative's Authority:

_____

SHENANDOAH VALLEY ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL PAYMENT POLICY

The purpose of this form allows Shenandoah Valley Orthopedics & Sports Medicine to treat you, bill any insurances you may have, share information with other health care offices/facilities, and to collect your account.

REGARDING INSURANCE: Our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

SPECIAL NEEDS: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your visit. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered. You are required at the time we see you to notify us if this is a worker's compensation or accident visit to avoid additional financial costs. If you are not covered by any insurance, let us know you are self-pay and ask us about our same day discount.

I authorize treatment by the providers of Shenandoah Valley Orthopedics & Sports Medicine. I authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits or injury benefits to Orthopedic Associates, Ltd. If the correct insurance information is not given to Orthopedic Associates, Ltd. or the proper referral is not obtained, then the patient will be responsible for the bill.

I acknowledge that I upon request, I may obtain a copy of a separate document, entitled "Notice of Privacy Practices" which sets forth Shenandoah Valley Orthopedics & Sports Medicine privacy practices and my rights regarding privacy of my protected health information.

EXPOSURE PROVISION: If a health care provider or any employee of Shenandoah Valley Orthopedics & Sports Medicine is directly exposed to my blood or other body fluids in a manner (such as through an accidental needle stick) which may transmit HIV, Hepatitis or other blood borne pathogen, I hereby consent to be tested for above viruses. I understand that Positive results will also be disclosed as medically necessary in connection with medical treatment or as required or permitted by law.

I hereby understand the financial policy of this office. I agree, in order for Shenandoah Valley Orthopedics & Sports Medicine to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails using any email address I provide to them. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that their collection agency may contact me/us as described above. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay 25% Attorney's fee, 35% Valley Credit Service fee, 6% Judgment Interest, Court Costs, and related collection fees incurred on my account. I hereby waive the benefit of my homestead exemption as to this debt. I also agree my employer may be contacted to verify employment status.

- **THE FEE FOR A RETURNED CHECK IS $25.00**
- **A $25.00-$35.00 FEE WILL BE CHARGED PER FORM. EXAMPLE: FMLA OR DISABILITY.**
- **THERE MAY BE A $25.00 FEE FOR ANY APPOINTMENTS YOU DO NOT KEEP WITHOUT AT LEAST A 24 HOUR NOTICE OF CANCELLATION.**
- **CO-PAYS ARE DUE IN FULL ON DATE OF SERVICE. YOU ARE RESPONSIBLE FOR OBTAINING A REFERRAL IF REQUIRED BY YOUR INSURANCE COMPANY. IF THIS REFERRAL IS NOT OBTAINED, YOU ARE RESPONSIBLE FOR PAYMENT IN FULL ON THE DATE OF SERVICE. IF IT IS DISCOVERED AFTER YOUR VISIT A REFERRAL IS NEEDED, YOU WILL BE RESPONSIBLE FOR THE FULL PAYMENT AT THAT TIME.**
- **INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE, WILL BE YOUR FULL FINANCIAL RESPONSIBILITY.**
- **YOUR RECORDS WILL BE KEPT FOR 6 YEARS FROM YOUR LAST DATE OF SERVICE.**

_____ _____
Patient or Guardian Signature (Must be 18 or older to sign) | Date

_____ _____
Please print patient name | Patient Social Security Number

_____ _____
Please print Guardian's name | Guardian's Social Security Number

Please have your insurance card(s) ready for the receptionist to copy. Thank you!