OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

Patient Medical History

Patient Name: _____ Date of Birth: ____/____/_____
Last First Middle Initial

Preferred Pronoun: _____ Gender: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____ Retired? ☐ Yes ☐ No

Primary Care Physician: _____ Referred By: _____

Date of Last Physical _____ Is this a work related injury? ☐ No ☐ Yes

Marital Status? ☐ Single ☐ Married ☐ Domestic Partner ☐ Seperated ☐ Widow/er ☐ Divorced ☐ Dependent

Social History

Do you drink alcohol? ☐ None ☐ History of Alcoholism ☐ Less than 7 drinks per week ☐ More than 7 drinks per week

Tobacco? ☐ Current ☐ Former ☐ Never

Type: _____ Years smoked: _____ Packs Per Day: _____

Ever Tried to quit? ☐ Yes ☐ No Years quit: _____

Do you currently vape? ☐ Yes ☐ No

Do you use recreational drugs? ☐ No ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Other _____

Exercise? ☐ Unable ☐ Sedentary ☐ Occasional ☐ Active Lifestyle ☐ Regular

Are you pregnant? ☐ Yes ☐ No ☐ Possibly How many children do you have? _____ Number living with you? _____

Personal Medical History

(Please check if YOU currently have or had the following diseases/conditions and check any that apply.)

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease (CAD)
- ☐ Crohn's disease
- ☐ Deep venous thrombosis (DVT)
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ High cholesterol
- ☐ Fibromyalgia
- ☐ Fracture _____
- ☐ Gout
- ☐ Headache/Migraine
- ☐ Hepatitis/Liver disease
- ☐ Hypertension
- ☐ Inflammatory bowel disease (IBS)
- ☐ Lyme disease
- ☐ Heart attack
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Psoriasis
- ☐ Renal disease
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Spinal stenosis
- ☐ Spondyloarthropathy
- ☐ Stroke/TIA
- ☐ Thyroid disease
- ☐ Valvular disease
- ☐ Antibiotic Resistant Infection /MRSA
- ☐ Communicable diseases
- ☐ Tuberculosis
- ☐ Anesthesia difficulties
- ☐ Other _____

Surgical History

(Please check if YOU have had any of the following surgeries/procedures. Check any that apply.)

- ☐ ACL Repair R / L
- ☐ Amputation _____
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Back/Spine Surgery
- ☐ Blood transfusion
- ☐ CABG
- ☐ Cardiac pacemaker
- ☐ Cardiac valve replacement
- ☐ Carpal tunnel release R / L
- ☐ Cataract extraction
- ☐ Cholecystectomy (gallbladder)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gastric bypass/sleeve
- ☐ Hernia repair
- ☐ Hip arthroscopy R / L
- ☐ Hip replacement R / L
- ☐ Hysterectomy
- ☐ Knee replacement, partial R / L
- ☐ Knee replacement, total R / L
- ☐ LASIK
- ☐ Meniscus surgery R / L
- ☐ ORIF Right/Left
- ☐ Rotator cuff repair R / L
- ☐ Small bowel resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other _____

Please continue to back page →

Family History

(Please check if anyone in your FAMILY has or had the following diseases/conditions; check any that apply.

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer_____
- ☐ Cardiovascular disease
- ☐ Colitis
- ☐ Congenital heart disease
- ☐ Congestive heart disease
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Drug dependency
- ☐ Genetic disease
- ☐ Gout
- ☐ Hearing loss
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Liver disease
- ☐ Mental disorder
- ☐ Migraines
- ☐ Muscle disease
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Peripheral vascular disease
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other _____

Review of Systems

(Please check if YOU are experiencing any of the following symptoms and check any that apply.)

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss
- ☐ Blurred vision
- ☐ Double vision
- ☐ Ear drainage
- ☐ Facial pain
- ☐ Headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nasal congestion
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Vision loss
- ☐ Asthma
- ☐ Cough
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Leg swelling
- ☐ Irregular heartbeat
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent urination
- ☐ Cold intolerant
- ☐ Hair loss
- ☐ Heat intolerant
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Poor coordination
- ☐ Memory impairment
- ☐ Muscle weakness
- ☐ Tremors
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin infections
- ☐ Skin lesions
- ☐ Back pain
- ☐ Bone/joint symptoms
- ☐ Neck stiffness
- ☐ Easy bleeding
- ☐ Bruising
- ☐ Contact allergy
- ☐ Contact dermatitis
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies
- ☐ Wheezing
- ☐ Seizures

Medications

[Please list ALL medications including prescriptions, over-the-counter, blood thinners (such as Coumadin, Plavix, aspirin), and weight loss medications]

Preferred Pharmacy: _____ Location: _____ Phone: _____

Medication	Dose	How Often
☐ None		
1.		
2.		
3.		
4.		
5.		
6.		

Allergies

(Please list ALL allergies including contrast dyes, metal, latex, medication or other.)

Allergen	Type/Name	Reaction (hives, rash, breathing difficulty, anaphylaxis)
☐ None		
☐ Contrast Dye		
☐ Latex		
☐ Metal		
☐ Medication:		
☐ Medication:		

The above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

M.D. Review _____ Date _____

Patient Financial Responsibilities

Orthopedic Physician Associates, clinics and imaging centers is committed to providing you with the highest-quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Orthopedic Physician Associates.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card(s) indicating the correct billing order, Social Security number, and Employer to enable us to submit your claims promptly and accurately
- Knowing your insurance benefits and limitations and Ensuring there is an authorization for our providers to treat you if it is required by yourinsurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram)and x-rays
- Paying your estimated portion of the charges at the time of service and any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with OPA at all times
- Providing us with at least 24 hours' advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputingpayment with your insurance carrier or have a balance over $100.00 with us, you must notify ourbusiness office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance: Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., casting, scopes, tests, x-rays) will bebilled separately from the office visit.

Surgery: If surgery is indicated, a pre-payment of both physician and facility fees is requiredfor all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Please note: Your surgical global period includes one pre-operative visit after the decision for surgery is made, the surgery, and follow-up visits during your post-operative period. Any services outside of your follow-up visit (e.g., such as casting, x-rays, tests, scopes) will be billed separately.

Non-Participating Insurance: If we do not participate in the insurance you have, we will file a claim as a courtesy. An out of network consent form and a $300.00 deposit may be required for all **new patients** and a $200.00 deposit for all **established patients**. All unpaid claims will become your responsibility 45 days following filingand will be immediately due and payable.

Uninsured Patients

Office Visits: A $300.00 deposit for **new patients** and a $200.00 deposit for all **established patients**, may be required toward services provided. If visit and services are paid in full at the time of service, we offer a 20% discount. Office procedures (e.g., casting, Scopes, office procedures, CTs, allergy shots, injections, tests, x- rays) will be billed separately from the office visit.

Surgery: For uninsured patients having surgery, we offer a 20% discount when charges arepaid before or on the day of service (see exclusions below).

Exclusions: The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third-party insurance claims or in other caseswhen the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third-Party Patients

We do not extend discounts for MVA-insured accidents, third-party insurance claims, or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. Thebill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personalinjury protection benefit on your MVA policy is exhausted, we will bill your private insurance at yourrequest provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work related, we will need the case number and carrier name prior to your visit in order tobill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, you may be required to pay a deposit at time of service.

Other Charges

No Show: Please provide us with at least 24 hours' advance notice if you need to cancel or reschedule an appointment. We may charge a $50.00 fee for missed clinical appointments, and a $100.00 fee for missed imaging and procedural appointments.

Please provide us with at least 48 hours' advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged forthe interpreter.

Forms: There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options: We accept all major credit/debit cards and money ordersfor payment (no post-dated or third-party checks). It is up to the sites discretion if they accept checks as a form of payment. Please verify prior to issuing payment in the form of a check.

Please note: We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts: We may assign an account to collections if balances are unpaid after 120 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements: If you are unable to pay your balance when due, pleasecontact our business office to make alternative arrangements. Any patient with a past-due amount may be denied additional service until the amount is paid or the patient is complyingwith an alternative payment arrangement.

Bankruptcy/Prior Bad Debt: Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care may be required to pay for their portion of new charges atthe time of service.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of patient	Relationship (parent, personal representative, etc.)

OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.
By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of OPA Ortho, PLLC

_____ _____
Signature of Patient or Guardian Date Time

_____
Printed Name

Effective: April 14, 2003 (Revised: September 23, 2013)

OPAORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

PATIENT NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE MM/DD/YYYY

MAY LEAVE DETAILED MESSAGE ON:

HOME VOICEMAIL: (_____) _____ - _____

WORK VOICEMAIL: (_____) _____ - _____

CELL PHONE: (_____) _____ - _____

OTHER: (_____) _____ - _____

Preferred number to be reached during business hours: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Other**

MAY LEAVE INFORMATION WITH:

SPOUSE/PARTNER: (_____) _____ - _____ NAME: _____

OTHER: (_____) _____ - _____ NAME: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

SIGNATURE _____ DATE _____
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL