Dr. Wallace Intake Form

Patient name: ______________________________

Date of birth: ______________________ Age: ______________

Height: ______________________ Weight: ______________

Problem/Injury: ☐ Right ☐ Left ☐ Both Body Part: ______________

Date of injury: ______________________________

Describe how it happened: ______________________________

Frequency: ______________________________

It is worsened by: ______________________________

It is improved by: ______________________________

Current pain level (pain from 1-10 with 10 being the highest level): ______________

Pain level at its worst: ______________________________

Which have you tried for your problem/injury?

- ☐ Anti-Inflammatory Medications
- ☐ Steroid Injections
- ☐ Gel Injections
- ☐ Physical Therapy
- ☐ Activity Modifications/Lifestyle Changes
- ☐ Weight Loss
- ☐ Brace
- ☐ Foot Orthotics/Shoe Lift
- ☐ Massage Therapy
- ☐ Narcotics/Opioids
- ☐ Surgery
- ☐ Walking Aids (Cane, Crutches,Walker)

Which of the following have you had done?

- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ EMG/Nerve Study
- ☐ Ultrasound

Is this a work related injury?: ______________________________

Were you treated in the ER? ☐ No ☐ Yes Which hospital?: ______________

How did you hear about us? ______________________________

Did another provider refer you to our office?: ☐ No ☐ Yes Which provider?: ______________

Primary Care Physician: ______________________________

Other Physicians for communication: ______________________________

(continued on back >>>)

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List all medical conditions: ____

____

Previous surgeries: ____

____

Current medications: ____

Preferred pharmacy: ____

Allergies to medications: ____

Relevant family medical history: ☐ No ☐ Yes Where?: ______________________

Tobacco use: Current use, how many_____ packs/day; Previous use, quit _____ ago; No tabacco use

Alcohol use: None Yes, how much ____________

Drug use: __________ frequency

Marital Status: ________________ Living situation: ________________

Occupation: ____________________________________ Employer: ________________________

Review of symptoms:

- ☐ Fever
- ☐ Chills
- ☐ Blurry Vision
- ☐ Sore Throat
- ☐ Nausea/Vomiting
- ☐ Depression or Anxiety
- ☐ Easy Bruising
- ☐ Difficulty Urinating
- ☐ Skin Rash
- ☐ Cough
- ☐ Fatigue
- ☐ Chest Pain
- ☐ Abdominal Pain
- ☐ Joint Pain
- ☐ Tremors
- ☐ Headache
- ☐ Other: __________

Infection history: ____

Pain management history: ____

Additional questions or concerns in relation to this injury: ______________________

____

SUMMIT ORTHOPAEDICS

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PATIENT REGISTRATION PROFILE

GO TO ORTHO ORTHOPEDIC URGENT CARE

Name: ______________________ Date of Birth: ______________

Guardian: ______________________ Social Security: ______________

Address: ______________________ Gender/Pronouns: ______________

Apt/Unit: ______________________ Preferred Language: ______________

City/State/Zip: ______________________ Interpreter Needed? ☐ Yes ☐ No

Email Address: ______________________

Cell Phone: ______________________ Home Phone: ______________________

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Email

Is it okay to leave a confidential message at this number regarding imaging and/or lab results? ☐ Yes ☐ No

Would you like a text message or email reminders for your future appointments? ☐ Text ☐ Email

Would you like to be emailed a link to our online payment portal for future payments? ☐ Yes ☐ No

Employment Information

Employment Status: ☐ Employed ☐ Retired ☐ Part Time ☐ Not Employed

Employer: ______________________ Employer Address: ______________________

Employer Phone: ______________________ City/State/Zip: ______________________

Medical Transportation Information

Do you utilize medical transport? ☐ Yes ☐ No If Yes, which company? ______________________

Insurance Information

Primary Care Physician: ______________________ PCP Phone: ______________________

Primary Insurance Company: ______________________ Secondary Insurance Company: ______________________

Primary Insurance Subscriber: ______________________ Secondary Insurance Subscriber: ______________________

Member Number: ______________________ Member Number: ______________________

Is this a Workers Compensation Injury? ☐ Yes ☐ No Claim Number: ______________________

Do you have an attorney? ☐ Yes ☐ No If yes, Attorney Name: ______________________ Phone: ______________

How Did You Hear About Us?

☐ TV Commercial ☐ Billboard ☐ Google/Digital Ads ☐ Employer ☐ ER/Urgent Care Clinic ☐ Family/Friend

☐ Social Media ☐ Previous Patient ☐ Insurance Referral ☐ Signage ☐ Other ☐ Dr. Referral ______________

Emergency Contact Name and Relationship: ______________________ Phone: ______________

ALERT: Please sign a Release of Information Form if you would like to give us permission to speak to this person about your medical care.

AUTHORIZATION TO VERBALLY DISCLOSE PROTECTED HEALTH INFORMATION

(without this form completed we are unable to speak to anyone besides yourself about your care)

Summit Orthopaedics, LLP & Go To Ortho, LLC are authorized to verbally disclose Protected Health Information (PHI) according to HIPAA regulations. Permitted reasons for released of PHI include: treatment, payment and healthcare options, or as otherwise allowed by specific signed authorization by the patient or authorized personal representative.

I hereby authorize verbal disclosure of the named individual's health information:

Patient Name	Date of Birth	Patient Telephone Number
Patient Address		

Permission to verbally discuss protected health information with the following family members and/or caregivers:

Name	Relationship	Telephone

-or- ☐ **I decline.** Please do not discuss my care with anyone other than allowed by HIPAA regulations.

I understand that certain information cannot be released without specific authorization as requested by State/Federal law. By initialing below, I authorize the release of the following protected or sensitive information:

☐ Alcohol and Substance Abuse ☐ Mental Health ☐ HIV and Sexually Transmitted Diseases

- Unless otherwise revoked, this authorization will expire on the following date: ________________
- If I do not specify an expiration date, this authorization will expire in 5 years.
- I understand I have the right to revoke this authorization. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by State or Federal Law.
- This form is not valid unless signed and dated.

Signature of Patient or Legal Representative	Date
If signed by Legal Representative, relationship to Patient	

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HIPAA ACKNOWLEDGMENT AND CONSENT

GO TO ORTHO ORTHOPEDIC URGENT CARE

I understand that ***Summit Orthopaedics, LLP and Go To Ortho, LLC,*** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle my health information. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the staff, employees, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices, if requested.

Patient Signature: ______________________________

Printed Name: ______________________________ Date: ______________

-*or-*

Patient Representative Signature: ______________________________

Patient Representative Printed Name: ______________________________ Date: ______________

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FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is a part of this treatment and care. Our fees for services, including office visits and surgeries, are based on the level of professional skill required, the severity and complexity of the injury or illness as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services, however, a precise estimate in advance may not be possible.

Insurance & Insurance Collection:

We make every effort to make sure your paperwork is filed accurately and promptly. We may bill your insurance as a courtesy at no expense to you. However, we will only bill insurance that has appropriate documentation presented at the ***time of service***. Secondary or other insurances that you may have must be presented at ***time of service*** if it is to be billed.

Each physician in this practice bills separately. You will not receive a statement until there is a patient balance. You may receive more than one statement if you see more than one provider in our office.

It is the patient's responsibility to inform us of any changes in insurance and to present the appropriate documentation. Failure to do so could result in any balance being transferred to patient responsibility.

If your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges. We will not submit more than two claims to your insurance company. Failure of your insurance company to respond will result in automatic transfer of the balance to your responsibility.

In order to provide you with the highest quality service, while keeping our billing costs low, we offer paperless patient billing through Breeze, our online patient portal.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS, CHECK CARDS, CHECKS* AND CASH.

Please understand that all personal balances are due within 30 days of receipt of the statement. We strongly recommend that you use the Breeze Patient Portal to satisfy your balance as it becomes due. Any returned checks will result in a $25.00 charge to your account and no further checks will be accepted. We may agree to accept installment payments on your account balance in the form of a payment plan. Please inquire directly with our billing office.

Participating Plans:

We have agreed to accept the discounted rate from many insurance plans; however, all co-insurance, co-payments and deductible balances are patient responsibility. Patient balances are due within 30 days of receipt of the statement. ***You*** are responsible for getting proper authorization/referral information in advance of your appointment. In the event that you do not have a valid authorization/referral at time of service, you may reschedule or sign a disclaimer that states you understand that there is not a valid authorization/referral in place for the service and that you will be responsible for the charges in the event your insurance company denies payment. Failure to obtain an authorization/referral or refusal to sign the disclaimer may result in rescheduling your appointment until this procedure is complete.

Non-Participating Plans:

We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. However, failure to present appropriate documentation regarding your insurance coverage or changes in insurance coverage will result in balances being transferred directly to patient responsibility. In the event your insurance company does not respond within 30 days, as required by law, you may be held responsible for all charges. You have the right to request a Good Faith Estimate from us at any time.

Secondary & Tertiary Insurance:

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary and tertiary insurers will pay as a function of what your primary carrier pays. We may bill your secondary and tertiary carrier as a courtesy, if proper information is received ***at time of service***. You are responsible for any balances after your insurance(s) has cleared.

Self Pay and Uninsured Patients:
Patient balances are due within 30 days of receipt of the statement. You have the right to request a Good Faith Estimate from us at any time. We may be able to offer a discount, agree to a payment plan or help direct you to other resources. Please inquire directly with our billing office.

Payments sent directly to Patient:
In the event your insurance company sends funds directly to you instead of our office, you can endorse the check and send it directly to us or forward a personal check for no less than the full amount sent by the insurance company, along with copies of the documentation supporting that payment to insure your account is properly credited. Funds received by the subscriber results in automatic transfer of the complete balance to patient responsibility, no secondary insurance will be billed, and no payment plan considerations will be given on the portion of funds received by the patient or subscriber.

Usual & Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Minor Patients and/or Divorce Decrees:
This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult. The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

Authorization & Consent:
I have read, understand, and agree to the above Financial Policy. I understand that the charges not covered by my insurance company, as well as copayments and deductibles, are my responsibility. I understand that in the event any unpaid balance is placed for collection with any third-party collection agency a fee of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees and any other fees so stated elsewhere.
I consent to and authorize that my insurance benefits can be paid directly to Summit Orthopaedics LLP, Go To Ortho LLC, and/or the provider's associated with the practice.
I consent to and authorize my physician to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
I consent to and authorize that Summit Orthopaedics LLP, Go To Ortho LLC, and/or the provider's associated with the practice can appeal payment denials or other adverse decisions on my behalf.

______________________	______________________	
Print Patient's Name	Patient's Date of Birth	
______________________	______________________	☐ SAME AS PATIENT
Print Responsible Party Name	Responsible Party Date of Birth	
______________________	______________________	
Signature of Patient or Responsible Party	Today's Date	