NEW PATIENT

Crovetti Orthopaedics & Sports Medicine

Today's Date______________________

PLEASE COMPLETE THIS FORM ENTIRELY

Gender: M F

*Patient Name ______________________ SS# ______________ DOB ____/____/____ Age______

Address ______________________________________ Apt# ______________

City ______________________ State __________ Zip______________ Marital Status ______________

Preferred Phone – Home or Cell? ______________________ Secondary Phone – Home or Cell?______________________

*Would you like to receive **appointment reminder calls** from our automated calling system? **Circle one:** YES NO

***If you agree to receive communications by email from our office** (which may include information about your medical care, appointments, billing, etc.), please provide us with your email address: ______________________________

Employer ______________________________________ Work Phone ______________

Occupation______________________________________ Department______________

*Parent/Spouse ______________________ SS# ______________ DOB______________

Phone ______________ Employer______________________ Work Phone ______________

Occupation ______________________________________ Department______________

*Emergency Contact ______________________ Relation to Patient ______________ Phone ______________
(Not living with you)

*Reason for Visit______________________________________ Date symptoms started______________

Is this related to an injury? YES / NO If yes, please describe injury ______________________

Is it work related? YES / NO **Is it auto related? YES / NO**

Have you seen a doctor for your problem? YES / NO If yes, when? ______________________

Were X-rays or scans taken? YES / NO If yes, when & where?______________________

Referred by Dr.______________________________________ Phone ______________

How did you hear about our office? Circle one: Physician Referral Hospital Referral Friend/Family Internet Billboard

TV Ad Theater Ad Magazine Ad Word of mouth Other______________

***Primary Insurance Company** ______________________________________ Phone______________

Policy ID Number ______________________________ Group Number ______________

Primary Insured ______________________ DOB ____/____/____ SS# ______________

Employer______________________________________ Effective date______________

Relation to Patient: Self______________ Spouse______________ Parent______________

We do not bill secondary insurance except in the case of Medicare, Medicaid or Tricare, but we ask that you provide it for authorization purposes.

***Secondary Insurance Company** ______________________________________ Phone ______________

Policy ID Number ______________________________ Group Number ______________

Primary Insured ______________________ DOB ____/____/____ SS# ______________

Employer______________________________________ Effective date______________

Relation to Patient: Self______________ Spouse______________ Parent______________

NEW PATIENT

MEDICAL HISTORY

ALL QUESTIONS MUST BE ANSWERED

MEDICATION (prescribed, OTC, and/or supplements) ***	DOSE	REASON FOR MEDICATION	SIDE EFFECTS

*** ________ CHECK IF A MEDICATION LIST IS ATTACHED.

ALLERGIES: ____

REVIEW OF SYMPTOMS: Are you currently having or have you had problems with: **(Please describe all YES responses)**

Eyes	NO	YES	____________
Ears, Nose, Throat	NO	YES	____________
Lungs, Breathing	NO	YES	____________
Digestion	NO	YES	____________
Bowel Movements	NO	YES	____________
Bladder Problems	NO	YES	____________
Diabetes	NO	YES	____________
High Blood Pressure	NO	YES	____________
Heart Disease	NO	YES	____________
Bleeding Problems	NO	YES	____________
Numbness/Tingling	NO	YES	____________
Blackout/Fainting	NO	YES	____________
Psychological Problems	NO	YES	____________
AIDS/HIV	NO	YES	____________
Cancer	NO	YES	____________
Arthritis	NO	YES	____________
Polio	NO	YES	____________
TB	NO	YES	____________
Epilepsy	NO	YES	____________

PAST MEDICAL HISTORY:

Surgeries/Hospitalizations	Date & Facility Name	Complications

Have you ever had general anesthesia? YES / NO

If yes, did you have any problems with anesthesia? YES / NO If yes, describe ______________________________

NEW PATIENT

SOCIAL HISTORY

Do you work in the home? Y/N   Are you a student? Y/N   Are you retired? Y/N   Do you live alone? Y / N

Are you employed? Y/N   Full time/ Part time   Occupation ____________________

Do you have children? Y / N   If yes, how many? __________

Do you exercise? Y/N   How often?   ______ Daily   ______ Weekly   ______ Monthly   ______ Rarely   ______ Never

What type of exercise?____________________

Do you have a history of substance abuse? Y / N   What type? ____________________

Do you currently smoke? Y / N   How many packs per day? __________   How many years? __________

Have you quit smoking? Y/N If yes, when? ______This year ______ >1 year ______ >5 years ______ >10 years ______Packs per day for ______ years

Do you drink alcohol? Y/N   How often? ____Daily, # of daily drinks______.   ______1-2/week ______1-2/month ______1-2/year ______Never

*MEDICARE PATIENTS:

Are you currently in a skilled nursing facility? Y/N If yes, which one? ____________________

Date of admission ____________________   Date of discharge ____________________

Have you been in a skilled nursing facility in the past six months? Y/N If yes, which one? ____________________

Date of admission ____________________   Date of discharge ____________________

HIPAA RELEASE

I authorize the following person(s) to be able to obtain my protected health information from Crovetti Orthopaedics & Sports Medicine. By listing someone below (such as a spouse, child, parent, trusted friend) you are giving our staff permission to communicate to another person about scheduling, treatment, care and billing as it pertains to you, the patient. If we do not have the information below, we **CANNOT** speak to anyone other than the patient about any protected health information. If patient is a minor, we are allowed to speak to the parent that consented to treatment.

Name:____________________ Relationship:____________________ Phone: ____________________

Name:____________________ Relationship:____________________ Phone: ____________________

Name:____________________ Relationship:____________________ Phone: ____________________

__________I wish no one to have access to my protected health information.

Consent for Treatment and Payment

I hereby request treatment by Crovetti Orthopaedics & Sports Medicine and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my treatment to my referring physician(s). I authorize Crovetti Orthopaedics & Sports Medicine to submit this claim on my behalf for the medical services provided. I hereby authorize my health insurance company to make payment(s) directly to Crovetti Orthopaedics & Sports Medicine, for any benefits that I may receive. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney, or third party payer is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services along with yearly deductibles. Payment for services is expected at the time services are rendered. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party. I understand that Crovetti Orthopaedics & Sports Medicine does not discriminate against any person on the basis of race, color, religion, gender or gender expression, sexual orientation, age, national origin, disability, or marital status.

Print Patient Name____________________

Signature of Patient____________________   Date__________
(*if patient is a minor – **DO NOT SIGN** – Parent/Guardian to sign next line)

*Signature of Responsible Party____________________   Date__________
(*if patient is a minor)

*Relation to patient____________________

Reviewed by Dr. ____________________   Date__________

PLEASE BE ADVISED OF THE FOLLOWING OFFICE/FINANCIAL POLICIES FOR CROVETTI ORTHOPAEDICS:

The following is a statement of the financial aspect of your medical treatment which must be read and signed prior to any treatment rendered by Crovetti Orthopaedics & Sports Medicine.

PAYMENT: We require that your copayment be paid at time of service. We accept cash, checks, all major credit cards and Care Credit. If payment arrangements are necessary for a balance due, we require that a payment be received every 30 days. Payment on any balance due must be received in the office within 30 days regardless if formal arrangements are made. If your account is placed with our collection agency for lack of regular payments or ignored attempts for collection, you will be responsible for all collection fees, and all future office visits must be paid in full at the time of service. This same policy will be required for all accounts that have filed bankruptcy.

PLEASE NOTE: Our office requires that you provide us with 24 hour notification to cancel appointments for office visits and MRI. You will be charged a $30 fee for any missed office visit and a $50 fee for MRI appointments that you fail to cancel or do not show for. There is also a $20 fee charged for every form completed by our staff or physicians. This includes disability forms & FMLA forms. PLEASE ALSO NOTE AS OF 5/31/18, there is a 48 hour notice required to cancel or reschedule a procedure with Dr. Tomas Kucera; you will be charged a $50 fee for any missed procedure with Dr. Kucera or if you fail to give a 48 hour notice to cancel or reschedule.

INSURANCE: We accept assignment of insurance benefits, and our billing department will file a claim with your primary insurance company as a courtesy. **As of Sept. 1st, 2015, our office does not bill secondary insurance. (Only exceptions are Medicare, Tricare, Champ VA, Teachers Health Trust, or Medicaid as secondary.)** We ask that you still provide your secondary insurance for authorization purposes. We will provide you with an itemized bill (billing statement can also be used) to submit to your secondary insurance for reimbursement.

You are responsible to provide us with CORRECT information regarding your insurance and demographic information. You are required to inform us of any changes immediately. Your insurance policy is a contract between you and your insurance company, and you are responsible for knowing your insurance rules regarding co-pays, deductibles, co-insurance, and when a referral or prior authorization is needed for testing or surgery. Every policy is different and we cannot be responsible for knowing what every carrier covers or disallows.
Please familiarize yourself with your specific insurance plan benefit. This information is available through your insurance company's plan booklet or their website.

We will obtain prior authorization, if required, before any testing or surgery we perform. Here are some vital questions you can ask your insurance before any such testing or procedure is performed:

- Have I met my deductible?
- How much is my co-pay &/or deductible?
- Are there any limitations to where I can have tests, labs or procedures done?
- Do I need prior authorization for procedures or planned hospital stays?

Because of the nature of our practice, insurances frequently request information regarding treatment from the member. You are required to provide this to your insurance in a timely manner. It is the patient's responsibility to make sure that their provider is paid for treatment received. Please be aware that the above information is vital and you are equally responsible with Crovetti Orthopaedics & Sports Medicine to understand and confirm your insurance benefits.

AGREEMENTS: In consideration of the treatment provided, the undersigned agrees:

1. That payments under my medical insurance benefits are made to Crovetti Orthopaedics & Sports Medicine, and that COSM may provide information concerning my treatments or that of my minor child to my health insurance carrier or its agents.
2. That I agree to pay for all attorney's fees, court costs, and filing fees, including charges that may be assessed by COSM's collection agency to pursue collection of my account. They also have the right to verify employment.
3. That I have read the Financial Policy above and understand and accept the terms of this policy

Print Patient Name______________________________ Date ________________

Signature of Patient______________________________ Date________________
(* If patient is a minor – DO NOT SIGN – Parent or Guardian to sign next line)

*Signature of Responsible Party______________________________ Date________________
(*If patient is a minor)

*Relation to patient______________________________

Signature of Witness______________________________ Date ________________

Notice of Privacy Practices

Crovetti Orthopaedics & Sports Medicine

Dr. Michael Crovetti, Dr. Caleb Pinegar, & Dr. Tomas Kucera

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to maintain the privacy of your health information, to follow the terms of this notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this notice. We reserve the right to change our practices and this notice and to make the new notice effective for all medical information we maintain. Upon request, we will provide a revised notice to you.

How We May Use or Disclose Your Health Information

We protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by us may be used or disclosed to a medical specialist, medical laboratory, or other healthcare provider providing treatment, and to bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required By Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensation programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders by postcard, voicemail messages, e-mail, letters and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- *Disclosures to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatment, or providers without authorization.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If your state law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow your state law.

You have the following rights with respect to your health information:

- **Access**: You have the right to review or get copies of your health information. To inspect or copy your health information, you must complete a **Request to Inspect/Access Medical Records** form and submit the request to the contact information below. We will charge you a reasonable cost based fee for expenses such as copies, mailing, and staff time. You will be able to review or have a copy of your health information within 30 days of the request. By law, we can have one 30-day extension of time for us to give you access or photocopies if we sent you a written notice of the extension. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- **Disclosure of Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, where you have provided an authorization and certain other activities, for the past 6 years, but not for disclosure made prior to April 14, 2003. To request an accounting, you must complete a **Request for Accounting of Disclosures** form and submit the request to the contact information below. We will usually respond to your request within 60 days of receiving it, but by law, we can have one 30-day extension of time if we notify you of the extension in writing. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost based fee for responding to these additional requests.
- **Restrictions**: You have the right to request that we place additional restrictions on our use or disclosures of your health information. To make such a request, you must complete a **Restriction of the Use of Patient Information** form and submit the request to the contact information below. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communications**: You may request communications of your health information by alternative means or at alternative locations. To request confidential communication of your health information, you must submit a request in writing. Your request must state how or when you would like to be contacted. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. We will accommodate all reasonable requests.
- **Amendment**: You have the right to request that we amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request for Amendment of Medical Records** form and submit the request to the contact information below. If we agree, we will amend the information within 60 days of the request. By law, we can have one 30-day extension of time to consider for amendment if we sent you a written notice of the extension. We may deny your request under certain circumstances.

If you would like to exercise one or more of these rights, contact us at the information listed at the end of this Notice.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. The revised notice will be posted in our office and a paper copy will be available upon request.

For More Information or To Report a Problem

If you have questions or would like additional information about our privacy practices, please contact us. If you believe your privacy rights have been violated, you may request and file a **Complaint Form** and submit the form to the contact information below, for which there will be no retaliation. If you prefer, you can discuss your complaint in person or by phone. You may also submit a written complaint to the U.S. Department of Health and Human Services.

Contact: Rebecca Herrmann, Office Manager: Telephone: (702) 990-2290 Fax: (702) 990-2297 Mailing Address: 2779 W. Horizon Ridge Pkwy. #200, Henderson, NV 89052

Print Patient Name ______________________ Patient Signature ______________________

Parent/Guardian (if patient is under 18 years of age) ______________________ Date ______________________