

**Crovetti Orthopaedics & Sports Medicine**

Today's Date \_\_\_\_\_

Gender: \_\_\_\_\_

**PLEASE COMPLETE THIS FORM ENTIRELY**

\*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 email communications from our office (which may include information about your medical care, any potential surgeries, appointments, billing, etc.), **please provide your email address:** \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Department \_\_\_\_\_

\*Parent/Spouse \_\_\_\_\_ DOB \_\_\_\_\_ Phone Number \_\_\_\_\_

\*Pharmacy Name \_\_\_\_\_ Phone Number \_\_\_\_\_

\*Pharmacy Address \_\_\_\_\_ \*Fax \_\_\_\_\_

\*Emergency Contact \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Phone Number \_\_\_\_\_  
**(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 Number \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Primary Insured \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Effective date \_\_\_\_\_

Relation to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_

\*Secondary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Primary Insured \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Effective date \_\_\_\_\_

Relation to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_

**MEDICAL HISTORY**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Pain location: \_\_\_\_\_

Acute or Gradually: \_\_\_\_\_ What is duration of pain: \_\_\_\_\_

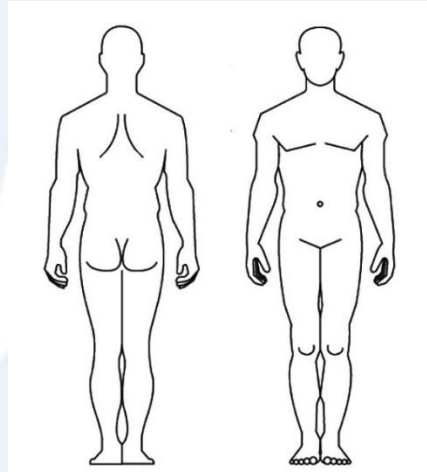
Pain severity: (circle one)  
0      1      2      3      4      5      6      7      8      9      10  
(0 being the least – 10 being the worst)

Quality of pain:

- Sharp       Aching       Throbbing       Numbness       Stabbing
- Shooting       Tender       Burning

Radiation of pain: \_\_\_\_\_

Location of radiation of pain: \_\_\_\_\_



What is pain consistency (circle one):      Constant      or      Intermittent

Aggravating factors for pain:      Bending      Exercise      Lifting      Sitting      Standing      Walking  
(circle those that apply)

Alleviating factors (circle those that apply):      Rest      NSAIDS      Heat      Ice      Nothing

Prior treatment (ex: physical therapy, injections, etc): \_\_\_\_\_

Studies (X-Rays, MRI, CT): \_\_\_\_\_

Do you have any HEART problems: \_\_\_\_\_

Do you or any family member have current or history of DIABETES: \_\_\_\_\_

Do you or any family member have current or history of CANCER: \_\_\_\_\_

Do you take any BLOOD THINNERS (please circle):      Aspirin      Heparin      Warfarin(Coumadin)

Rivaroxaban(Xarelto)      Dabigatran(Pradaxa)      Apixaban(Eliquis)      Fondaparinux(Arixtra)

Clopidogrel(Plavix)      Prasugrel(Effient)      Dipyridamole/Aspirin(Aggrenox)

Other: \_\_\_\_\_

**CURRENT MEDICATION LIST**

<b>Date Started</b>	<b>Medication Name</b>	<b>Dose</b>	<b>Frequency Taken</b>

**Relevant medical history:**

Surgeries: \_\_\_\_\_  
 \_\_\_\_\_

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

**Review of Symptoms**

Please circle any symptoms you have had in the last 6 months

- Eyes**                                      sudden visual loss, transient visual loss
- HEENT**                                      recent head injury, neck stiffness
- Cardiovascular**                              irregular heartbeats, dyspnea on exertion
- Respiratory**                                      shortness of breath, bloody cough
- Gastrointestinal**                              nausea, jaundice
- Genitourinary**                                      incontinence, urinary retention
- Integument**                                      pigmentation changes, new skin lesions
- Neurologic**                                      additional symptoms, except as noted in the HPI
- Musculoskeletal**                                      limitation of motion, muscular weakness
- Endocrine**                                      weigh gain, weight loss
- Psychiatric**                                      compulsive behaviors, impulsive behaviors
- Heme-Lymph**                                      easy bleeding, lymph node enlargement or tenderness

Have you ever had general anesthesia?    YES / NO

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

**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 \_\_\_\_\_



## **Notice of Privacy Practices**

**This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.**

We at Crovetti Orthopedics & Sports Medicine are committed to keeping the security and confidentiality of personal information that you provide to us. We do not sell or share patient information with marketing groups outside of our practice and its affiliate groups. This policy covers patient information including personal, financial or health information about a patient or patient relationship. We disclose this policy to you as required by federal and Nevada state regulations. If you have questions after reading this notice, please ask to speak with the practice manager.

### **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 email, voicemail messages, 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 providers without authorization.

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

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and receive a copy of your protected health information.
- The right to request amendment or correction to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

I have read and understand the above notice:

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent/Guardian (if patient is under 18 years of age)

\_\_\_\_\_  
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 a \$20 fee charged for every form completed by our staff or physicians. This includes disability forms & FMLA forms. There is a 48 hour notice required to cancel or reschedule a procedure with Dr. 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.**

**There is a 48 hour notice required to cancel or reschedule a surgery with our orthopedic doctors; you will be charged a \$100 fee for any surgery canceled or rescheduled with our orthopedic doctors with less than 48 hours' notice.**

**INSURANCE:** We accept assignment of insurance benefits, and our billing department will file a claim with your insurance company as a courtesy. We ask that you provide us with your photo ID (driver's license or passport) and your insurance card(s) as we require proof of insurance, and so that we may obtain pertinent information that is on your insurance card(s) for authorization and billing purposes.

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.

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 \_\_\_\_\_