Name: _____
DOB: _____
Chart: _____
Date: _____

Midwest Orthopaedics, PA

☐ *Burrel C. Gaddy, MD* ☐ *Joel R. Lane, MD* ☐ *Robert C. Sharpe, MD* ☐ *Adam Wait., DO*
☐ *Jeremy Cowgill, PA-C* ☐ *Chris Welch, PA-C*

Date:_____

Patient Name: _____

DOB _____ AGE _____

Address _____

City, State, Zip _____

Practice Provider _____

Circle one Married Single Divorced Widowed

Home Phone _____ ☐ Cell _____

☐ Work _____ *(Mark primary number)*

Email Address _____

Do you wish to receive paper or electronic statements?

☐ PAPER ☐ ELECTRONIC (requires email address)

How do you prefer to be contacted for appointment reminders? ☐ Phone ☐ Text ☐ Email

Primary Insurance Information

Insurance Company _____

ID# _____

Policyholder Information

Patient ☐ *(If not patient, fill in additional information.)*

Policyholder Name _____

DOB _____ Relationship to Patient _____

Address _____

Policyholder's Employer , address and phone number:

_____

Guarantor Information (For Minor Patients)

Same as insurance policy holder ☐

(If not subscriber, fill in additional information below.)

Name of Guarantor _____

DOB _____ Relationship to Patient _____

Address _____

Guarantor's Email _____

Guarantor's Phone number _____

Guarantor's employer address and phone number:

_____

_____

Demographic Information

Race (Check one)

☐ American Indian/Native American ☐ Asian
☐ Black/African American ☐ Asian ☐ White
☐ Other ☐ Declined to answer.

Race (Check one)

☐ Hispanic Non-Hispanic Unknown

Primary Language (Check one)

☐ English ☐ Spanish ☐ Chinese
☐ French ☐ Japanese ☐ Portugueses
☐ Russian ☐ Yiddish ☐ Other _____

Emergency Contact

Name _____

Phone: Home _____

Work _____ Cell _____

Relationship to patient _____

Who referred you to our office?

Patient Consent to Leave Detailed Message Information

I give my consent to the physicians and staff of Midwest Orthopaedics, P.A. to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care at the numbers listed on this form.

Check one ☐ I agree ☐ I disagree

Signature _____

If agree, leave the name(s) of the people with whom the information may be left (include phone number):

Consent to Treat/Assignment of Benefits

I, the undersigned, agree to examination and orthopaedic care by the physicians of Midwest Orthopaedics, P.A., and I consent to medical treatment as deemed appropriate by the attending physician.

I authorize my insurance benefits to be paid directly to the physicians of Midwest Orthopaedics, P.A., and I authorize the release of pertinent medical information to the insurance carriers and/or their representatives. Even though Midwest Orthopaedics, P.A. filed my insurance, I understand that I am responsible for seeing that the entire bill is paid in full.

Signature _____

Date _____

Name: _____
DOB: _____
Chart:
Date: _____

Chief Complaint

What body part? _____

Which side? ☐ Right ☐ Left ☐ Both

Date of Injury/Onset of symptoms _____

Was this an injury? ☐ YES ☐ NO
Was this an Auto Accident? ☐ YES ☐ NO
Was this a Work Injury? ☐ YES ☐ NO
If so, was it reported? ☐ YES ☐ NO

Primary Care Physician_____

Height _____ **Weight**_____

Are you pregnant? ☐ YES ☐ NO

Latex Allergy: ☐ YES ☐ NO

Habits *(type and amount per week)*

Tobacco:_____ Alcohol_____ Caffeine_____

Recreational drugs _____ Exercise_____

Medication Allergies

Name of drug, reaction (*hives, nausea etc.)* & when noted

_____

_____

Medication, dosage & when started.

(Will provide separate sheet, if more space is needed)

_____

_____

_____

Hospitalizations, surgeries or major illnesses

(Will provide separate sheet, if more space is needed)

_____

_____

Smoking Status

☐ Current every day smoker ☐ Former smoker

☐ Current some day smoker ☐ Never smoker

☐ Smoker-current status unknown

☐ Unknown if ever smoked

Pharmacy Information

Pharmacy Name_____

Pharmacy Address _____

Pharmacy Phone Number _____

I agree that Midwest Orthopaedics, P.A may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature _____

Employer

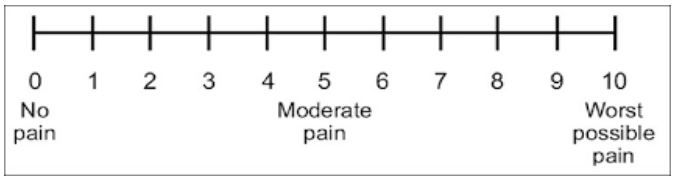
_____

Job Duties

_____

_____

Rate your pain level for this problem today



☐ Yes ☐ No HIV-AIDS
☐ Yes ☐ No Hepatitis/Liver disease
☐ Yes ☐ No Cancer/Malignancy
☐ Yes ☐ No Thyroidism (hyper or hypo)
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Angina/Heart Attack/Chest pain
☐ Yes ☐ No High____/Low___ Pressure
☐ Yes ☐ No Bursitis
☐ Yes ☐ No Emphysema/COPD
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Frequent infections
☐ Yes ☐ No Polio
☐ Yes ☐ No Phlebitis
☐ Yes ☐ No Anemia
☐ Yes ☐ No Migraines

☐ Yes ☐ No Paralysis
☐ Yes ☐ No Stomach Ulcers
☐ Yes ☐ No Recurrent Stomach Pain
☐ Yes ☐ No Neuritis/Neuralgia
☐ Yes ☐ No Pain-Stiffness in Neck/Back
☐ Yes ☐ No Asthma
☐ Yes ☐ No Weakness of Hands or Feet
☐ Yes ☐ No Tingling of Hands or Feet
☐ Yes ☐ No Meningitis
☐ Yes ☐ No Swelling/Pain in Joints
☐ Yes ☐ No Muscle Spasms
☐ Yes ☐ No Unconscious spells
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Concussions or Head injury
☐ Yes ☐ No Trembling of hands
☐ Yes ☐ No Psychiatric Condition

☐ Yes ☐ No Alcoholism/drug addiction
☐ Yes ☐ No Stroke
☐ Yes ☐ No Sciatica
☐ Yes ☐ No Rash
☐ Yes ☐ No Weight Loss/Gain
Other
(list):_____

_____

Name: _____
DOB: _____
Chart: _____
Date: _____

8800 W. 75th Street, Suite 350
Tel. (913) 362-8317

Midwest Orthopaedics, P.A.

PATIENT FINANCIAL POLICY

Shawnee Mission, KS 66204
Fax. (913) 362-0169

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility. The patient or responsible party is responsible for seeing that the entire bill is paid in full.

PATIENTS MUST COMPLETE PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR

WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT. WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. IT IS YOUR RESPONSIBILITY TO NOTIFY US IF YOUR ADDRESS, PHONE NUMBER, INSURANCE CARRIER OR POLICY BENEFITS HAVE CHANGED. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED BY NOT PROVIDING THE MOST CURRENT, CORRECT INSURANCE AND BILLING INFORMATION TO OUR OFFICE.

INSURANCE: Your insurance carrier determines the amount of your co-pay, and how co-insurance and deductible amounts are applied to your claims. Midwest Orthopaedics cannot reduce the out-of-pocket amount determined by your carrier. You will be responsible for any charges deemed non-covered by your insurance carrier. **If we are not contracted with your insurance carrier, you will be responsible for payment in full at the time of service.**

COPAYMENTS: Your insurance carrier requires that we collect your co-pay at the time of service. This is part of your contract with your insurance carrier. Please be prepared to pay the co-pay at each visit. If you are unable to pay your co-pay, you may be asked to reschedule your appointment. Additionally, we cannot accept bills larger than $20.

SELF-PAY: For patients not covered by health insurance, payment is due at the time of service. For new fracture patients, a payment of $400.00 is expected on the day of your appointment before seeing a health care provider. For new non-fracture patients, a payment of $300.00 is expected on the day of your appointment before seeing a health care provider. For established patients, our business office will contact you prior to your appointment with an estimate of the visit charges. A discount off regular fees is offered for Self-Pay patients paying at the time of service.

PATIENTS PLANNING SURGERY: If you are covered by a commercial insurance plan, a member of our business office will contact you regarding your insurance benefits and payment arrangements. You will be required to pay any co-pay, co-insurance or deductible prior to having surgery. Self-Pay patients are required to pay the estimated fees in full prior to surgery. Please contact the business office for more information.

REFERRALS: If your insurance plan requires a referral from your primary care physician. It is YOUR responsibility to obtain it prior to your appointment. If you do not obtain your referral YOU MAY BE REQUIRED TO RESCHEDULE.

ACCIDENT/WORKERS COMP CASES: All work comp cases must be scheduled through the work comp carrier. Auto accident cases must have the date of injury, claim number, insurance company claims address and phone number and name and phone number of the claim adjuster/contact person from the insurance company. We will only bill the **patient's** auto insurance company. **WE DO NOT BILL THIRD PARTY LIABILITY CARRIERS.** Additionally, you must have health insurance that Midwest Orthopaedics is contracted with in order for us to submit unpaid claims after your auto benefits run out. You will be financially responsible for medical services related to accident or workers comp if insurance fails to pay in full.

MEDICARE: We will submit your charges to Medicare. You will be responsible for any deductible and co-insurance as determined by Medicare. If you have a secondary insurance, we will submit these balances to them for payment.

FORMS/PAPERWORK: There is a $15 per form fee for the completion of paperwork or forms relating to disability. This fee is collected prior to completion of the paperwork and for each time the paperwork is required. Allow five working days for completion.

RETURNED CHECK FEES: You will be charged $25.00 for any checked returned unpaid by your bank for any reason.

NON-PAYMENT: Failure to make payment in full in 90 days or honor your payment arrangement will result in your account being sent to collections. If your account is placed with a collection agency, a fee equal to 20% of the past-due balance may be added to your account.

We accept most forms of payment including credit and debit cards, cash and checks. You may also pay over the phone or on our website at www.midwest-orthopaedics.com. If you have any questions please call Shannyn Tinberg, CPC, Billing Manager, at 913-322-7815.

RESPONSIBLE PARTY:_____ **DATE:**_____

Name: _____
DOB: _____
Chart: _____
Date: _____

HIPAA Notice of Privacy Practices

Midwest Orthopaedics, P.A.
8800 W. 75th St. Suite 350
Shawnee Mission, KS 66204
(913) 362-8317

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your heath care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

Name: _____
DOB: _____
Chart: _____
Date: _____

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected heath information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want this restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and become effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature _____ Date _____