201 S. Lloyd St. Suite 110
Aberdeen, SD 57401
(605)229-0205

ABERDEEN ORTHOPEDICS & SPORTS MEDICINE

Need copy of Drivers Licenses &
Front and Back of Insurance Cards

Date:_____

PATIENT INFORMATION

Patient Name _____ **DOB** _____ **Age**___ ☐ **Male** ☐ **Female**
Last First MI

Current Address _____
Street Apt # City State Zip

Billing Address _____
(*If different from address listed above*) Apt # City State Zip

Phone Number: Home(____) _____ **Cell**(_____) _____ **Other**(_____)_____

SSN _____-_____-_____ **E-Mail**:_____

Parent(s) Name (if a minor)_____**Phone#**_____

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino **Preferred Language:** _____

How did you hear about us? (Please check all that apply) ☐Friend/family member ☐Physician referral ☐Yellow Pages
☐Newspaper ☐Radio ☐Other:_____

Patient Status: ☐ Single ☐Married ☐Divorced ☐Child

Spouse's Information (if applicable)

Name_____ DOB_____ SSN_____

Employer Name_____ Phone #_____

Occupation_____

Emergency Contact:

Name:_____ _____Relationship _____ _____Phone # _____

Student Status ☐ Part-Time ☐ Full-Time **Name of School**: _____

Patient Employment Information:

Employer Name_____ Address_____

Occupation_____ _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired Phone # _____

Guarantor Information---- Party Responsible for Payment of Personal Balance (if patient is under the age of 18)

☐ **Guarantor Information: Same As Patient Address**

Relationship to Patient ☐ Self ☐ Spouse/Partner ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other_____

Guarantor Name_____ DOB_____SSN_____

Address _____ Phone #_____

_____

Aberdeen Orthopedics & Sports Medicine

Patient Name:_____
Date:_____

INSURANCE INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD TO BE SCANNED BY THE RECEPTIONIST

Primary Insurance	**Secondary Insurance**
Name of Insurance Company_____	Name of Insurance Company_____
Policy's Holder's Name _____	Policy's Holder's Name _____
Policy's Holder Soc Sec #_____	Policy's Holder Soc Sec #_____
ID Number _____	ID Number _____
Group Number _____	Group Number _____
Policy's Holder's Birthday_____	Policy's Holder's Birthday_____
Relationship to Patient _____	Relationship to Patient _____
Effective Date _____	Effective Date _____

IS THIS VISIT DUE TO A WORK COMP INJURY? __YES __ NO

IF YES, HAVE YOU FILED A FIRST REPORT OF INJURY WITH YOUR EMPLOYER? __YES __NO

IS THIS VIST DUE TO A MOTOR VEHICLE ACCIDENT? __ YES __NO

IF YES, HAVE YOU FILED A CLAIM WITH YOUR LIABILITY OR MOTOR VEHICLE INSURANCE? __YES__NO

Date of Accident _____ **Claim Number** _____

Adjuster/Case Worker _____ **Phone Number** _____

Claims Mailing Address _____ **Phone Number:** _____
_____

AUTHORIZATION TO PAY ABERDEEN ORTHOPEDICS & SPORTS MEDICINE

I authorize payment directly to Aberdeen Orthopedics & Sports Medicine of benefits payable under this policy. I understand that I will be financially responsible to Aberdeen Orthopedics & Sports Medicine for any charges not covered by this policy. In effort to eliminate the expense of billing and collection, we asked that you pay for these services as they are rendered.

It is not our intention to cause undue hardship; however, collecting our billings as efficiently as possible will insure quality healthcare to the community, now and in the future. To protect our patients from increased fees due to losses incurred by non-complying patients, accounts that become delinquent may be subject to collection activity.

All Charges are due and payable within 30 days of date of service. Co-pays are due at the time of visit. We file our insurance claims as a courtesy. We do not negotiate disputed claims with your insurance company. A service charge of 1.5% will be added for accounts over 90 days past due. We accept Visa, MasterCard, Discover or American Express. Anyone needing to make financial arrangements should do so with the billing department prior to your procedure.

We will assist with pre-authorization for surgical procedures, MRI's and Physical therapy visits. However, it is the patient's responsibility to make sure that insurance has approved the procedure. It is the patient's responsibility to know their insurance plan limitations. If you have questions regarding your coverage, please contact your insurance carrier directly.

If you are currently a Medicaid patient on the managed care program, **PLEASE BRING YOUR CURRENT MEDICAID CARD AND THE MANAGED CARE REFERRAL CARD** at the time of your appointment or your appointment will **NEED TO BE RESCHEDULED**.

Work compensation Claims: All worker's compensation claims need to be reported to your employer prior to your appointment. If your visit involves a worker's compensation claim, notify the receptionist immediately. You must provide us with the insurance carrier name, address, your claim number and case manager. If this is not provided your account will be considered a self-pay account and the responsibility of the patient or patient guarantor.

Litigation Claims: We will agree to hold your claims while you are working with an attorney to allow you adequate time to reach a settlement as long as a letter of protection has been obtained from your attorney. If at any time during this period you decided you want your claims filed to your private health insurance we will do so but, will not hold the remaining balance pending your litigation settlement. This will become your responsibility with normal collection proceedings if not paid in a timely fashion.

Motor Vehicle Accident Claims: We will submit claims to your insurance carrier if we are provided the complete information. If incomplete or no information is provided it will be considered a self-pay account and be responsibility of the patient or patient guarantor.

Print Patient Name _____ **Date** _____

Signature _____

(Parent or Guardian must sign if patient is under the age of 18)

Patient Name:_____
Date:_____

REVIEW OF SYSTEMS

Please check the box next to each item to indicate which of the following symptoms you are experiencing:

Primary Care Physician and Phone Number:

_____

_____

Preferred Pharmacy and Phone Number:

_____

_____

Referring Physician:

_____

What are you being seen for today?

_____

_____

_____

_____

Brief Explanation of Injury/Condition:

_____

_____

_____

_____

_____

Date of Injury:_____

How would you currently rate your pain?

(*Please circle one)*

(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Excruciating)

Height:_____

Weight:_____

CURRENT MEDICATIONS- PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

_____

_____

_____

_____

_____

_____

_____

CONSTITUTIONAL

☐ **Weight Loss**

☐ **Fever**

☐ **Chills**

☐ **Fatigue**

☐ **Decreased Appetite**

CARDIOVASCULAR

☐ **Chest Pain**

☐ **Palpitations**

☐ **Swelling in legs**

☐ **Night Cramps**

RESPIRATORY

☐ **Chronic Cough**

☐ **Shortness of Breath**

☐ **Wheezing**

GASTROINTESTINAL

☐ **Heartburn**

☐ **Nausea**

☐ **Vomiting**

☐ **Blood in Stool**

☐ **Constipation**

GENITOURINARY

☐ **Painful Urination**

☐ **Blood in Urine**

ALLERGY/IMMUNE

☐ **Recurrent/Resistant Infection**

Please list all known allergies and reactions.

Include metals, medical tape, latex products

_____

_____

_____

_____

_____

ENT/MOUTH

☐ **Loss of Hearing**

☐ **Hoarseness**

☐ **Sore Throat**

EYES

☐ **Vision Changes**

MUSCULOSKELETAL

☐ **Joint Stiffness**

☐ **Joint Pain**

☐ **Joint Swelling**

☐ **Limb Swelling**

☐ **Numbness**

☐ **Tingling**

☐ **Back pain**

☐ **Muscle loss**

INTEGUMENTARY

☐ **Skin Rash**

☐ **Skin Lesions**

☐ **Breast Lumps**

☐ **Skin Wound**

HEMATOLOGIC/LYMPH

☐ **Easy Bleeding**

☐ **Easy Bruising**

☐ **Swollen Lymph Nodes**

NEUROLOGICAL

☐ **Headaches**

☐ **Dizziness**

☐ **Seizures**

☐ **Unsteady Gait**

PSYCHIATRIC

☐ **Depression**

☐ **Alcohol Use (excessive)**

☐ **Drug Use (excessive)**

☐ **Anxiety**

ENDOCRINE

☐ **Excessive Thirst**

☐ **Excessive Urination**

☐ **Hair Loss**

☐ I am experiencing none of the symptoms listed above.

Aberdeen Orthopedics & Sports Medicine

Patient Name:_____
Date:_____

PAST MEDICAL HISTORY

Please check the box next to each item to indicate which of the following conditions you have been treated for. Also include a brief explanation when applicable

GENERAL

- ☐ **Birth Defect**_____
- ☐ **Cancer**_____
- ☐ **Diabetes**_____
- ☐ **Epilepsy/Seizure**_____
- ☐ **HIV/AIDS**_____
- ☐ **Thyroid Disease**_____
- ☐ **Polio**_____
- ☐ **Concussions**_____
- ☐ **Rheumatic Fever**_____

BLOOD

- ☐ **Anemia**_____
- ☐ **Blood Clots**_____
- ☐ **MRSA/Staph Infect**_____

RESPIRATORY

- ☐ **Asthma**_____
- ☐ **Lung Disease**_____
- ☐ **Pneumonia**_____
- ☐ **Pulmonary Embolism**_____
- ☐ **Tuberculosis**_____

CARDIOVASCULAR

- ☐ **Pacemaker/Defibrillator**_____
- ☐ **Heart Problems**_____
- ☐ **Hypertension**_____
- ☐ **Stroke**_____

GASTROINTESTINAL

- ☐ **Bowel Disorder**_____
- ☐ **Gallbladder Problems**_____
- ☐ **Hepatitis/Jaundice**_____
- ☐ **Liver Problems**_____
- ☐ **Reflux Disease**_____
- ☐ **Ulcer**_____

GENITOURINARY

- ☐ **Kidney Problems**_____
- ☐ **Sexually Transmitted Disease**_____

ORTHOPEDIC

- ☐ **Arthritis (Degenerative, Rheumatoid)** _____
- ☐ **Fracture**_____
- ☐ **Nerve Compression/Irritation**_____
- ☐ **Osteomyelitis (bone infection)**_____
- ☐ **Spinal Disc Problem**_____

SPECIAL CONSIDERATIONS

- ☐ **Pregnant or Attempting Pregnancy**_____
- ☐ **Claustrophobic**_____
- ☐ **Metal Implants**_____

Other Medical Problems_____

_____

_____

_____

Surgical History _____

_____

_____

_____

_____

Previous Orthopedic Injuries_____

_____

FAMILY HISTORY OF DISEASE/ILLNESS Please indicated if any of your family members have had any major health conditions such as asthma, heart attack, hypertension, cancer, arthritis, etc..

Mother ☐ Living ☐ Deceased

_____

Father ☐ Living ☐ Deceased

_____

Sister/Brother ☐ Living ☐ Deceased

_____

Sister/Brother ☐ Living ☐ Deceased

_____

Son/Daughter ☐ Living ☐ Deceased

_____

Son/Daughter ☐ Living ☐ Deceased

_____

Paternal GM ☐ Living ☐ Deceased

_____

Paternal GF ☐ Living ☐ Deceased

_____

Maternal GM ☐ Living ☐ Deceased

_____

Maternal GF ☐ Living ☐ Deceased

SOCIAL HISTORY

Tobacco Use

☐ Never ☐Current Smoker ☐ Former Smoker ☐Chews Tobacco

Amount: _____Pack/Cans(s) day for _____Year(s)

Quit Smoking/Chewing: _____Year(s) ago

Yes ☐ No ☐ Drug Use:_____

Yes ☐ No ☐ Alcohol Use: Amt____ per _____ (day/week/month/year)

Yes ☐ No ☐ Caffeine Use: Amount per day_____

Yes ☐ No ☐ Exercise: _____Mins _____X's a week

****If you need more room please use back of this sheet***

Patient Name:_____
Date:_____

PATIENT CONSENT AND RELEASE FORM

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me as they deem appropriate. I understand that my provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse the recommended treatment.

RELEASE OF INFORMATION: I hereby authorize Aberdeen Orthopedics and Sports Medicine to release any medical or other information necessary to collect payment for charges incurred.

FORM COMPLATION: I understand forms that need to be completed by the physician; a minimum of $10 per page will be charged for any of the following forms: Workers' Compensation, FMLA, Disability, Supplemental Insurance, or any other form needed to be completed by the physician. Charges are to be determined by the physician or physician's office staff. These charges are to be paid before forms are filled out.

RELEASE OF MEDICAL RECORDS FOR RESEARCH: Your medical records may be released for research purposes unless you object. We may receive requests from medical or scientific researchers for a copy of our patient records in order to conduct a research study. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose. The researchers cannot use patient names or other identifying characteristics when reporting any results of their research

PATIENTS' RIGHT TO PRIVACY: I acknowledge that I have received a copy/have been made aware of Aberdeen Orthopedics and Sports Medicine's privacy practices. If I would like a copy of Aberdeen Orthopedics' privacy notice, I will ask for it.

COMMUNICATION REGARDING MY CARE: I hereby authorize Aberdeen Orthopedics to disclose the specific information described below, only for purposes and parties described below. **PLEASE DO NOT LEAVE BLANK, WRITE N/A** if not applicable. I can revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Description of the specific information to used or disclosed:

_____

_____

Person or entity authorized to request the information:

_____

_____

Print Patient Name _____ Date _____

Signature _____ Relationship to Patient:_____
Parent must sign if patient is under the age of 18 *If other than self*

FOR ALL MEDICARE PATIENTS

Medicare Eligibility Based on:

☐Age ☐ Disability ☐ End Stage Renal Disease

CIRCLE YES OR NO FOR EACH QUESTION

1. Do you or your spouse work for a company that provides you with health insurance? ☐Yes ☐No
2. Has treatment for this accident or illness been Authorized by the Veterans Administration? ☐Yes ☐No
3. Are you entitled to any benefits under the Federal black lung program? ☐Yes ☐No
4. Is this patient a nursing home resident? ☐Yes ☐No

Updated
07/2013

Patient Name:_____
Date:_____

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES
April 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

If you would like to review the full Notice of Privacy Practices (NPP), ask the receptionist for a copy. If you have any questions, Please contact our Privacy Officer, Becky Graves.

This notice describes our privacy practices. All our entities, sites and locations follow the terms of this notice. Our entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION
We understand that health information about you and your health care is personal and we are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, whether made by your personal doctor or other working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to: make sure that health information that identifies you is kept private; give you this notice of our legal duties And privacy practices with respect to health information about you, and follow the terms of this notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization. There are also various other ways in which we may use or disclose your information: appointment reminders, health-related services and treatment alternatives, to allow oversight of the quality of the healthcare we provide, to allow worker's compensation claims, as required by by subpoena in lawsuits and disputes, and various uses as required by law or to avert a serious threat to health or safety. The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you: right to inspect and copy, right to amend, right to an accounting of disclosure, right to request restrictions, right to request confidential communications, right to a paper copy of this notice. Information on how to exercise these rights can be found in the NPP or can be obtained from Becky Graves.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health Information we already have about you as well as any information we receive in the future. We will post a copy of the current notice In our facility. Each time your visit us for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Becky Graves. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

Patients Copy to Keep