



201 S Lloyd St Suite 110/ Aberdeen, SD 57401/229.0205

### PATIENT INFORMATION

**IS THIS VISIT DUE TO A WORK COMP INJURY? \_\_\_ YES \_\_\_ NO** If yes, you **MUST** provide your work comp insurance carrier information **TODAY** or your medical insurance will be billed by us and you will be responsible for submitting your work comp claims.

**IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT? \_\_\_ YES \_\_\_ NO** If yes, you **MUST** provide your auto insurance information **TODAY** or your medical insurance will be billed by us and you will have to take care of submitting claims to your auto insurance.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street Apt # City State Zip

Phone H (\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthday \_\_\_\_\_

Sex \_\_\_M\_\_\_F Marital Status: S D M W **What are you being seen for today?** \_\_\_\_\_

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

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Parents' Name (if Patient is a minor) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### INSURANCE INFORMATION - PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance \_\_\_\_\_ ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy's Holder's Name \_\_\_\_\_ Policy's Holder's Birthday \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Policy's Holder's Name \_\_\_\_\_ Policy's Holder's Birthday \_\_\_\_\_

### WORK COMP OR AUTO INSURANCE INFORMATION

Date of Accident \_\_\_\_\_ At Work \_\_\_ Car Accident \_\_\_

Name of Insured \_\_\_\_\_ Insurance Company (Work Comp or Auto) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster \_\_\_\_\_

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

Thomas Harbert, M.D.



201 S Lloyd St Suite 110/ Aberdeen, SD 57401/229.0205

201 S. Lloyd St. Suite 110  
Aberdeen, SD 57401  
605-229-0205 (office)  
605-229-5513 (fax)

## PATIENT HISTORY

Is this a workers comp claim? \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Workers Comp. Billing Address \_\_\_\_\_

Medication Allergies: \_\_\_\_\_  
Other Allergies: \_\_\_\_\_

Please make an (x) by any of these conditions you may have or have had in the past:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart disease                       | <input type="checkbox"/> Liver disease                 | <input type="checkbox"/> Lumbar spine disorder  |
| <input type="checkbox"/> High blood pressure                 | <input type="checkbox"/> Bowel disease                 | <input type="checkbox"/> Severe headaches       |
| <input type="checkbox"/> High cholesterol                    | <input type="checkbox"/> Cancer (past or present)      | <input type="checkbox"/> Tuberculosis/TB        |
| <input type="checkbox"/> Lung disease                        | <input type="checkbox"/> Anemia or other blood disease | <input type="checkbox"/> Muscle disease         |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Blood clots                   | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Hypoglycemia (low Glucose)          | <input type="checkbox"/> Bleeding tendency             | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Thyroid disease                     | <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Chronic skin disease   |
| <input type="checkbox"/> Stomach disease                     | <input type="checkbox"/> Seizures                      | <input type="checkbox"/> Sleep apnea            |
| <input type="checkbox"/> Kidney, bladder or prostate disease | <input type="checkbox"/> Nerve impairment              | Other _____                                     |
| <input type="checkbox"/> Joint replacement                   | <input type="checkbox"/> Cervical spine disorder       | _____   |

### Past Medical Conditions

Approximate Date: \_\_\_\_\_ Condition: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Condition: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Condition: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Condition: \_\_\_\_\_

### Current Medications (includes non-prescription products)

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_  
4) \_\_\_\_\_ 5) \_\_\_\_\_ 6) \_\_\_\_\_  
7) \_\_\_\_\_ 8) \_\_\_\_\_ 9) \_\_\_\_\_

### Personal Habits

Do you drink caffeinated beverages (coffee, tea, soda)? \_\_\_\_\_ Daily intake? \_\_\_\_\_  
Do you drink alcoholic beverages? \_\_\_\_\_ If yes, \_\_\_\_\_ drinks/day, week, month  
Do you smoke or chew tobacco? \_\_\_\_\_ If yes, /day, \_\_\_\_\_ years of use  
If no, any prior nicotine use? \_\_\_\_\_ Years

### Orthopedic or Other Major Surgeries

Approximate Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Approximate Date: \_\_\_\_\_ Surgery: \_\_\_\_\_





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### PATIENT CONSENT AND RELEASE FORM

**Yes**  **No** **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.

**Yes**  **No** **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.

**Yes**  **No** **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. By checking the "Yes" box, you authorize this release, but you may also revoke this agreement at any time by notifying us in writing.

**Yes**  **No** **ASSIGNMENT OF BENEFITS:** I hereby request that payment of insurance benefits be made directly to Aberdeen Orthopedics and Sports Medicine on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or me. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly. Any balance due after 90 days will be subject to a finance charge of 1.5% per month (18% annual percentage rate).

**Yes**  **No** **WORKERS' COMPENSATION OR MOTOR VEHICLE ACCIDENT:** The services being rendered today are related to a workers' compensation injury or a motor vehicle accident.

**Yes**  **No** **DISCLOSURE OF PRESENCE:** I understand that during my visit, my friends, family, employers, or others may call to inquire about my presence at Aberdeen Orthopedics. I authorize Aberdeen Orthopedics to disclose information about my presence at this facility to anyone who may inquire.

**Yes**  **No** **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.

**Yes**  **No** **COMMUNICATION REGARDING MY CARE:** I hereby authorize Aberdeen Orthopedics to verbally communicate the following people with regard to my care:

Family Member/Caregiver \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_



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## **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 Officers, Laura Small and Vicki Cramer.

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 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 for Laura Small and Vicki Cramer.

### **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 either Laura Small or Vicki Cramer. 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.