STAFF INITIALS:_____

HUFF ORTHOPAEDICS & SPORTS MEDICINE

DATE: _____ **SSN**: _____ PHONE: Home _____

Cell _____

NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M F

MARITAL STATUS: Single Married Divorced Separated

EMAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT/RELATION: _____ PHONE: _____

PRIMARY CARE DOCTOR NAME & FACILITY: _____

ARE YOU CURRENTLY ENROLLED IN A HOSPICE PROGRAM_____YES_____NO

*2012 US Federal Government Requirement:	Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Unknown	
	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	
	Language	

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY# _____ GROUP# _____ EMPLOYER: _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER _____

POLICYHOLDER NAME: _____ DOB: _____ SSN: _____
(If different than self)

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY# _____ GROUP# _____ EMPLOYER: _____

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER _____

POLICYHOLDER NAME: _____ DOB: _____ SSN: _____
(If different than self)

Revised 11/18/2017

HUFF ORTHOPAEDICS & SPORTS MEDICINE

Huff Orthopedic Group, INC

HIPAA Privacy Policy, Record Release, Benefits Assignments Authorization to Treat

Patient Name: _____ Chart # _____

1. I have received a copy of Huff orthopedic group, Inc. Notice of Privacy Policies and understand that my protected health information may be released to other healthcare providers, hospitals, insurance companies, etcetera as outlined in the Privacy Policy without written consent by patient/parent or guardian.
2. I authorize the release of any medical information, records or x-rays to my insurance company, referring physician, and or my attorney.
3. I authorize payment by my insurance carrier (Medicare, Medicaid, BCBS, and any Commercial insurance) directly to Huff Orthopedic Group Inc. for any charges incurred for medical treatment at said facility in which care is rendered.
4. I authorize physicians and physician assistants of Huff Orthopedic Group Inc. to administer medical treatments or diagnostic testing/ procedures to include but not limited to injections/aspirations, x-rays, manipulations, debridement and any other procedure deemed necessary/proper for treatment.

I authorize Huff Orthopedic Group Inc. physician's and staff to speak to and release information to the following individuals regarding my health care.

Spouse's name: _____ Phone #_____

Other: _____ Relationship_____ Phone #_____

Other: _____ Relationship_____ Phone #_____

Other: _____ Relationship_____ Phone #_____

I wish to be contacted in the following manner (check all that apply)

Home phone ____ Work phone ____ Email ____ Written communication to my home address ____

By signing below, I certify that I have read and understand the above statements and received a copy of the Huff Orthopedic Group Inc. Privacy Policy.

_____ _____

Signature: Patient/Parent/ Legal Guardian Print Name: Patient/Parent/ Legal Guardian

Relationship to the patient: _____ Date: _____

HUFF ORTHOPAEDICS & SPORTS MEDICINE

MEDICAL INFORMATION

Who referred you here? (circle one) Self Family Dr Emergency Room Clinton Urgent Care

Other: _____

Who is your family doctor? _____ Date Last Seen: _____

Do you have a pain agreement with another doctor? YES NO With Whom? _____

Why are you here to see the doctor? _____

Accident or Injury? YES NO Date of Injury/Onset: _____

Describe: _____

Is your problem or injury work related? YES NO

Pain Scale: 1 (minimal pain) to 10 (horrible pain) 1 2 3 4 5 6 7 8 9 10

Describe pain: Sharp Dull Throbbing Stabbing Numbness/tingling Aching

Prior treatments? Injections Physical Therapy MRI findings _____

What makes symptoms better? _____

What makes symptoms worse? _____

PAST MEDICAL HISTORY: (Circle all that apply)

Medical:				
	Negative	COPD	Liver Disease	Broken Bones
	Asthma	Depression	Vascular Disease	Hepatitis A B C
	High blood pressure	Anxiety	Poor circulation	HIV
	High cholesterol	Diabetes IDDM	Stomach ulcers	Blood Clots
	Heart disease	NIDDM	Rheumatoid arthritis	Pulmonary embolism
	Lung disease	Kidney disease	Osteoarthritis	
	Tuberculosis	Dialysis	Osteoporosis	
	Cancer: Type: _____		Status/stage: _____	
	Other: _____			

Surgical:			
	Open heart	Gallbladder	Shoulder arthroscopy
	Cardiac catheterization	Appendectomy	Rotator Cuff Surgery
	Cardiac stents	Hysterectomy	Carpal tunnel
	Abdominal surgery	Knee arthroscopy	Hand surgery
	Fracture fixation	Knee replacement	Foot surgery
	Tonsillectomy	Hip replacement	Pacemaker
	Neck surgery	C-section	Defibrillator
	Back surgery	D & C	
	Other _____		
	Date of last surgery: _____		

Which hand do you write with? Right Left

Revised 11 28 2017

HUFF ORTHOPAEDICS & SPORTS MEDICINE

Medications: Coumadin Plavix Aspirin

Other: _____ _____

_____ _____

_____ _____

_____ _____

Preferred Pharmacy _____

Consent to Download Medication History From Your Preferred Pharmacy ___Yes ____No

Allergies: Penicillin Sulfa

Other: _____ _____ _____

_____ _____ _____

Family History: Is there any family history of: (circle all that apply)

Bleeding disorders Heart attack or other heart problems Stroke Diabetes Cancer Other _____

_____ NO FAMILY HISTORY OF THE ABOVE

Is Mother living? Yes No Age of Death _____ Cause _____

Is Father living? Yes No Age of Death _____ Cause _____

Social History:

Do you smoke? Yes No Packs per day _____

Do you drink alcohol? Yes No Drinks per day _____

Marital status: Married Single Divorced Widow/Widower

Type of Occupation:

Child	Meat processing	Other: _____
Clerical	Professional	
Disabled	Retired	
Farming	Sales Person	
Food Service	Student	
Manual labor	Teacher	
Manufacturing	Truck driver	

Review of Systems:

Do you have: Chest pain Fever Vomiting Shortness of breath Recent unexplained weight loss

Huff Orthopaedics & Sports Medicine
Financial Policy & Authorization for Treatment

MEDICAL RECORDS

§ 90-411. Record copy fee.
A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs.

- **.75 cents** per page charge for the first 25 pages
- **.50 cents** per page for pages 26 through 100
- **.25 cents** per page in excess of 100 pages
- Medical Record copying services must be ***paid in full prior to completion***. For compliance purposes, the patient information portion of the form must be completed and signed prior to acceptance, along with payment.

COPY OF X-RAYS

- $25 processing & supplies fee per copy of x-ray series requested
- X-Ray copying services must be ***paid in full prior to completion***. For compliance purposes, the patient information portion of the form must be completed and signed prior to acceptance, along with payment.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Huff Orthopaedics & Sports Medicine.

I authorize Huff Orthopaedics & Sports Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date	Signature	Printed Name

Huff Orthopaedics & Sports Medicine

Financial Policy & Authorization for Treatment

*PATIENT NAME:*_____ *CHART#* _____

ACCIDENT/WORKERS COMP CASES: Patients shall be financially responsible for medical services related to accident/workers comp which are denied. Patients ***MUST*** notify Huff Orthopaedics & Sports Medicine of the date of injury, claim #, insurance company address, phone #, and contact person's name prior to coming to the office. If Worker Compensation is denied, and you have private health insurance, they may be billed. We will require, for this reason, your private insurance information upon the first visit. If neither Workers Comp nor private insurance pays, you, the patient are responsible for payment.

NON-PARTICIPATING INSURANCE PLANS or 'OUT OF NETWORK": I understand if I elect to be treated by any physicians or any provider at Huff Orthopaedics & Sports Medicine who does not participate in my insurance plan, I am directly responsible for my balances, and may not be reimbursed by insurance. Further, I understand I am responsible for care not covered by my insurance plan, such as DME (Durable Medical Equipment) or Orthotic devices. You may also receive a bill from SME for your DME.

Please initial: _____

THIRD PARTY INSURANCE FORMS (DISABILITY, FMLA ETC)

There is a charge for completing any form that is not directly related to a reimbursement of medical services. Our Practice charges:

- **$15** processing fee per FMLA form
- **$25** processing fee per Disability form
- Form services must be ***paid in full prior to completion***. For compliance purposes, the patient information portion of the form must be completed and signed prior to acceptance, along with payment.